Surgical News

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS **JULY 2012**

Inside, the Winter issue of Post Op with A Surgeons' Guide to Townsville

The College of Surgeons of Australia and New Zealand

Academic Surgery

Research for the future

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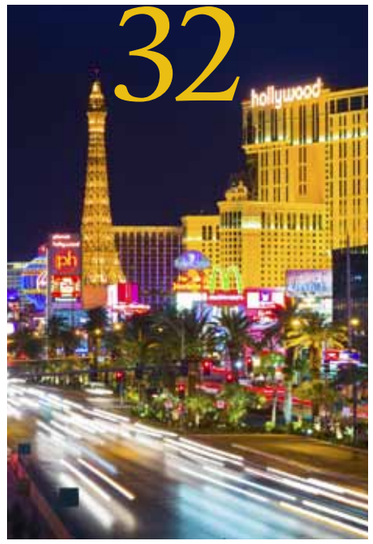

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ON THE COVER: Successful Scholar Simon Luibinas at work. Photo courtesy of Pierre Smith (Department of Surgery (RMH/WH), University of Melbourne).

President's Perspective

Continuing Professional Development

Maintaining our skills

It was only the other day that I was reflecting about the enormous changes in Continuing Professional Development (CPD) over the past 10 years. I remember on my first visit to Council having convened a Younger Fellows Course listening to Bruce Shepherd extolling its importance. In essence most surgeons have always been enthusiastic and dedicated about ongoing professional development, but the past 10 years have brought greater rigour ensuring CPD compliance is integral to the maintenance of our clinical standards.

Much of this has been internally driven among our peers, clinical interest groups, specialist societies and through the College. However, there is now no doubt that the regulators are starting to focus more strongly on this area. With the introduction of AHPRA (Australian Health Practitioner Regulation Agency), CPD is now compulsory in Australia meaning that Australia has caught up with New Zealand after many years. In effect, no CPD, no registration.

As a profession, and as a professional organisation, we have a commitment to the community about the maintenance of our ongoing standards and an understanding that as a profession we need to "self-regulate' to maintain those standards. This is more than words.

Whether we like it or not, the community and, as agents within the community, the media and Government expect us to demonstrate that we are actively maintaining the standards of our profession. If we are not seen to be actively engaged in this space, then someone else will step into it and the consequences will not be palatable.

With the moving regulatory environment, we would then end up with a system as cumbersome as the UK or in the realm of compulsory revalidation by examination that is occurring in parts of the US. I do not see the UK or US models as ones that would be preferred. The demand is then on us to ensure our current system is robust.

What are those standards we expect of Fellows and Trainees undertaking CPD? How do we monitor them? How do we enforce them? What should be the consequences for Fellows who refuse to engage in CPD? These are issues currently being considered by the Board of Professional Development and Standards.

Within the CPD framework, the College has traditionally had a triennial model. With the varying demands of Fellows needing to adjust their CPD as they transition to different forms of practice and the ongoing requirement to reflect the educational value of different activities, the model has become quite complex.

The College's approach to the program is under active review at present with the aim of simplifying the structure and having an annual, rather than triennial, program. Also the burden of validation has been increasing. There is no doubt that validation rates need to be increased to ensure confidence in the system, but the burden of undertaking the documentation needs to be streamlined. How can we make this easier for Fellows?

With all of this as background, June Council will be considering a number of changes to the CPD program. Hopefully, the categories will be simplified, the educational value of the activities highlighted and the processes streamlined so they can be readily incorporated into the CPD online area of the new website.

Most of you would now be familiar with the CPD online area of the new website. It is much easier to capture CPD activities in 'real-time' and also attach and store any associated documentation or confirming material that would be required for verification.

The College is highly conscious that we are moving to a mobile, 'tablet based' IT world and we are progressively re-configuring our systems to handle this.

The web-redevelopment was the first substantial step and will have a number of our educational programs progressively delivered in this manner. The College has also re-developed interfaces to the Mortality Audits and soon the new Mobile Audit and Logbook Tool will be available. The latter will be providing online capability for Trainees, but importantly Fellows will also be able to audit all of their procedural activities. These developments along with our new approach for CPD will enable Fellows to complete these requirements in the most IT facilitated way possible.

Mike Hollands
President

LEADERSHIP IN A CLIMATE OF CHANGE

14 to 15 September, Sydney

Change provides an ongoing challenge to surgical leaders. Understanding your own style of leadership and adapting it to the situation and personalities of others in the workplace is crucial in today's dynamic world.

This workshop encourages a journey of self-discovery by undertaking a psychometric behavioural profiling exercise, indicating an individual's preferred leadership style. Group discussions identify alternative leadership styles, the value of emotional intelligence and a range of appropriate management styles that can enhance workplace relations.

According to Prof Clifford Hughes FRACS, CEO of the Clinical Excellence Commission who enrolled in the diploma and helped facilitate this workshop, "I was mightily impressed with the way the presenter worked with a group of clinicians, not known for their ready acceptance of some of the issues raised. It was great fun…. The informal discussions illustrate the way in which the presenter engaged each member of the group and developed their enthusiasm, including me. More importantly, I think there is still a lot to learn."

For further information, please contact Professional Development Department.

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The view from New Zealand

Prioritising has meant change

Prioritisation is not a new process for surgeons – we have been deciding who first needs access to our skills for a very long time. However, with the increasing demand for surgery (and often limited funds to address that challenge) we require better resources to undertake the task of prioritisation.

In New Zealand, prioritisation has been a major issue for clinicians, health service managers and Health Ministry staff since the start of the New Zealand Priority Access Project in the 1990s. With limitations on the funds available for health services, including elective surgical services, it was not possible to treat in a timely manner all whom it had been determined would benefit from surgery.

The government of the day decided that it was inappropriate for patients to be on a waiting list and thinking they would receive publicly funded surgery when, in reality, there was little likelihood of that occurring within a reasonable time frame. It set the maximum time on a public waiting list at six months. As there were insufficient funds to treat all on the elective list within that time-frame, patients needed to be prioritised more carefully than before and those with lesser need who were not able to be given "certainty" of receiving surgery within that time were to be advised of that.

Those patients were allocated to one of two categories. Those with a higher priority level were placed on an "active review" list. These patients had to be reassessed by the hospital every six months for a maximum of 18 months. If at the end of that time they had not had their surgery because their priority level had not increased, their care was to be returned to their GP with advice on what to do should their condition worsen.

Patients with the lowest priority level (compared with others on the lists) were returned immediately to the care of their GPs. The only options for patients returned to their GP's care were to pay for private care or await deterioration of their condition so that they could be referred back to the public system for reassessment and the possibility that their prioritisation score would be sufficient for them to be placed on the 6 month list for surgery.

This arrangement ensured greater transparency, allowing patients to know whether their surgery would be publicly funded and within what time frame. However, it also meant that a considerable number of patients assessed as benefiting from a surgical procedure were not able to have that funded from the public purse. Those patients either had to have private surgery or live with their condition. Approximately one third of New Zealanders have some form of private health insurance and are able to access financial assistance for private surgical care. However, many patients cannot afford private treatment (whether it is fully self-funded or even part funded by an insurance company). Any rationing of surgical services has the potential to adversely affect the lifestyle of those patients and their capacity to work.

New Zealand surgeons have had to give considerable thought to prioritisation scoring tools and to ensuring their reliability and fairness. Different groups of hospitals were left to develop their own prioritisation tools and, over time, many of these have developed into national scoring tools – either for designated procedures or for a surgical specialty.

Surgeons, along with Health Ministry staff and managers, have been involved in the development of Clinical Priority Access Criteria (CPAC) scoring tools from the outset. The Ministry's goal was the creation of a robust means of prioritisation resulting in a numerical measure of the need for surgery (based upon such factors as pain experienced, threat to life, disability, ability to work, threat to independence and perceived benefit).

Those with the greatest need would score the highest and those where there was only marginal benefit compared with conservative care would score the lowest. It was hoped that this would result in an even distribution of scores so that at any time (dependent upon funding available) the threshold score for access to publicly funded surgery could be altered and

"As there were insufficient funds to treat all on the elective list within that time-frame, patients needed to be prioritised more carefully"

relative equity would be maintained. However, it has proved impossible to achieve a measure of prioritisation to this level of discrimination and clumping of scores rather than a regular linear progression has resulted.

In addition, it has so far proved impossible to adequately compare the needs of patients with diverse surgical conditions within the larger specialties, let alone consider the relativity between specialties. The result has been the development of numerous scoring systems across the country and an often inadequate and cynical application of these by clinicians who wish to assist the individual patient before them. With financial incentives (and disincentives) linked to their use, in some hospitals use of CPAC has resulted in a degree of conflict between the clinicians scoring the patients and managers driven by financial imperatives.

Research has shown a degree of reliability of CPAC scoring ("Prioritisation of Elective Surgery in New Zealand: The Reliability Study"; NZMJ 29 July 2005 Vol 118 No. 1219), but it also acknowledged that using surgeons who agreed to participate in the study may have introduced some bias.

The current New Zealand government has increased funding for elective surgery which has increased the number of patients receiving treatment. However, there are still many who do not receive publicly funded surgery because they cannot be treated within the designated six months. This has led to initiatives such as the Canterbury Charity Hospital Trust which uses volunteer health staff to treat patients whose prioritisation scores make them ineligible for publicly funded elective surgery and who cannot afford private care.

Work on prioritisation tools continues in New Zealand and there is still debate over their reliability, especially at the margin where a patient will or won't be placed on the elective waiting list. The College continues to advocate for additional funds and for improved mechanisms that will enable the delivery of care to a greater number of patients. In Australia, the College is playing a key role in the debate over the introduction of a nationally consistent elective surgery categorisation system. Surgeons must remain involved in these processes, both as advocates and as developers and users of appropriate prioritisation tools.

Michael Grigg
Vice President

Medics warned on App use

THE increase in the use of smartphones has some experts concerned about the use of Apps by medical specialists.

Experts say that some apps work well, many do not take personal circumstances into account.

President of the Australian Medical Association, Steve Hambleton has said that while some apps can be helpful, there were risks for patients.

"There's no computer made that can match the medical training that a medical practitioner can get because there's so many non-verbals you can't feed into a computer," Dr Hambleton said.

***Canberra Times*, 12 June**

Helping our neighbours

WA plastic surgeon Mark Duncan-Smith has recently returned from another trip to Vanuatu to conduct surgery and train local surgeons.

The visit, organised by Interplast and funded by Rotary, help the young residents with surgery for the results from disease or deformity.

Dr Duncan-Smith will soon return on a follow-up visit, "The operations are going to make an incredible impact on those kids' lives."

***Sunday Times*, 3 June**

Health package for ailing Tassie hospital

LAUNCESTON General Hospital will receive a $30 million cash injection from the Federal Government. The funding comes after Director of Surgery and Fellow Berni Einoder told Federal Health Minister Tanya Plibersek that budget cuts meant some patients wouldn't receive the surgery they needed.

The Health Minister said "In consultation with my Tasmanian Labor parliamentary colleagues and Member for Denison Andrew Wilkie, the government has decided to fund a blitz on elective surgery targeted at patients who have been waiting the longest."

***Launceston Examiner*, 15 June**

A teenager from the Gaza strip has had her final bout of surgery to fix a facial deformity after eight years of operations.

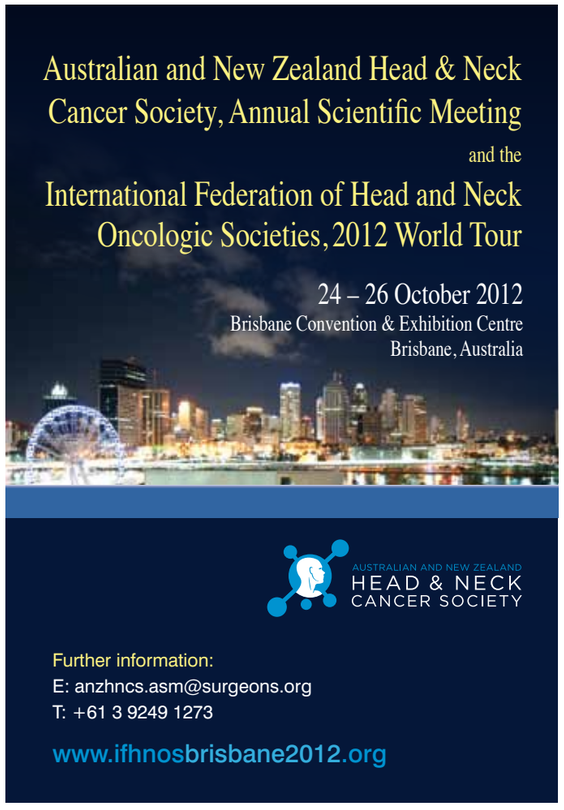
A surgical journey

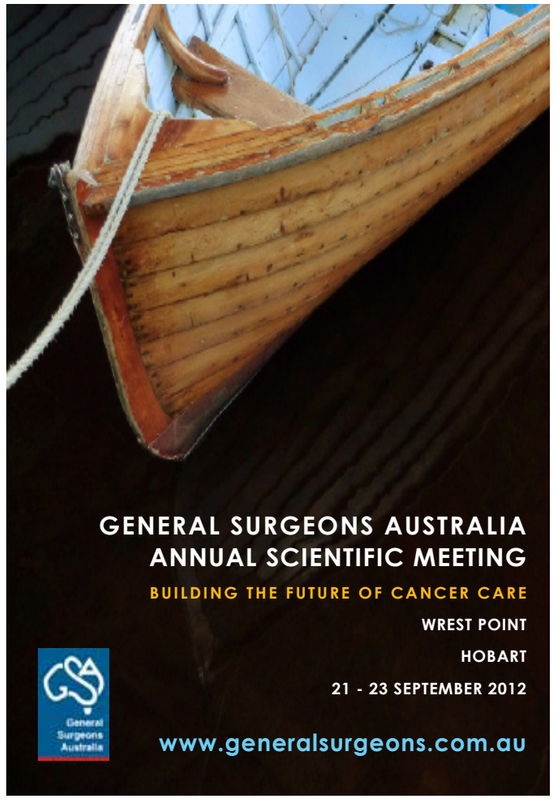
EMAN Tabaza has been coming to Australia since she was eight years old, first having a tumour removed and later to rebuild her face.

Craniofacial surgeon and Fellow Tony Holmes led the initial operation and also completed the work on her face recently.

A message was left for the surgeon from Eman, "Thank you for all your help, it has really changed my life."

***The Age*, 8 June**



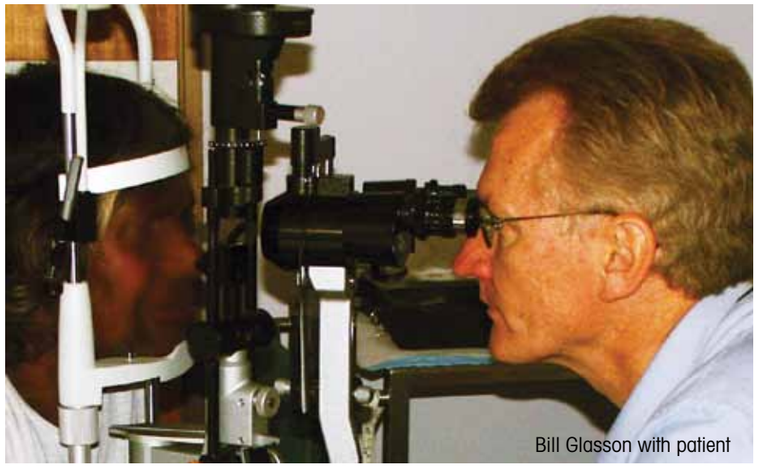


Action for visible results

This is the second in a series of four articles based on the findings of the Evidence Based Actions Plans (EBAPs), commissioned by the Foundation for Surgery as part of its commitment to addressing the health inequities in our Indigenous communities

The Evidence Based Action Plans are action orientated overviews that identify how improvements in the delivery of surgical services to Aboriginal and Torres Strait Islander peoples can contribute to better health outcomes in their communities. The research was led by Professor Russell Gruen at Monash University and Alfred Health and Associate Professor Kelvin Kong, Chair of the College Indigenous Health Committee, in collaboration with relevant research, clinical and policy experts from around Australia.

In this article, Dr Bill Glasson, President of the Royal Australian and New Zealand College of Ophthalmologists, who has volunteered in a number of Indigenous communities and is a member of the Indigenous and Remote Eye Health Service taskforce, discusses cataracts among Aboriginal and Torres Strait Inlander people.



Bill Glasson with patient

Treatable Cataracts – The major source of blindness in our Indigenous Population

National Reconciliation Week was recently celebrated across Australia. The theme this year was 'Let's Talk Recognition'. With this in mind I'd like to bring up some disturbing yet preventable facts.

An Indigenous person is 6.2 times more likely to be blind than the general population. Cataracts are still the major cause of blindness in Indigenous adults, and alarmingly only 65 per cent of those currently needing cataract surgery have been operated on.

Despite the Australian health system being one of the most balanced, fair and equitable systems in the world, all Australians are clearly not getting access to the health care they need.

Ophthalmologists, more so than probably any non-GP speciality, from the days of Fred Hollows, have, and continue to provide extensive outreach services across Australia. The key to a sustainable and successful outreach service is the appointment of regional and local coordinators, as well as an appropriate and sustainable funding model.

I commend the Foundation for Surgery which commissioned Evidence Based Action Plans which identified multiple barriers to the delivery of cataract surgery to Indigenous communities. These include limited availability of specialist eye services, geographic remoteness, lack of transport, poverty, culturally inappropriate services, communication problems, cost and fear of treatment.

To address these problems The Foundation for Surgery has suggested two service delivery models. They are:

1) Visiting specialist (outreach) clinics.
Consultations occur in the community with surgery in regional hospitals. This model assists in improving the education of local staff and facilitates culturally appropriate follow up.

2) Cataract Eye camps.
Surgical teams and their equipment are transported to local Indigenous communities. These camps have not been adequately assessed in Australia.

In my experience there is no easy answer, but undoubtedly the doctors, nurses and allied health workers, who currently live and work in remote Indigenous areas, are strongly committed to the health of its inhabitants. They need to be engaged and involved when considering how to build long-term sustainability for the region. In addition to this, raising awareness and education levels amongst Indigenous communities is also critical.

Bill Glasson
President RANZCO

The article on the Evidence Based Action Plan into Otitis Media was published in the May 2012 issue of *Surgical News*. The topics of the two subsequent articles are: trauma and renal transplantation.

An initiative of Foundation for Surgery

Evidence Based Action Plan

Cataract among Indigenous Australians

Cataracts are changes that lead to clouding of the normally transparent lens in the eye. Cataracts are 12 times more common in Australia's Indigenous population than in the non-Indigenous population. Sight is a basic human right, but vision impairment and blindness due to cataracts is a major problem in our Indigenous community. Approximately three per cent of Indigenous adults have impaired vision due to cataracts. Surgical treatment of cataracts is safe and effective, with low complication rates. Despite this, access to cataract surgery in parts of Australia is below that recommended by the World Health Organisation for developing countries.

Three procedures are available for age related cataracts: phacoemulsification, manual incision surgery and extracapsular surgery.

Indigenous patients have worse eyesight than non-Indigenous patients at the same age. They are younger, have longer inpatient stays, are more likely to have diabetes, more likely to be admitted post surgery and their eyes do not always correct to normal or near-normal visual acuity compared with non-Indigenous counterparts post-operatively.

Indigenous populations have increased risk of developing post-operative complications, especially posterior capsular opacification (PCO). Effective treatment of this problem relies on patient recognition and access to follow up.

Fee for service models are associated with the highest surgical through-put and the least waiting time and cost per attendance, but in remote and rural areas specialist eye services are limited, ophthalmic equipment is often of poor quality, through-put is less and waiting times are longer.

Research is required to determine how access to surgery can be improved for all Indigenous people. Consideration should also be given to funding regional eye services. These services will require surgeons and coordinators who can partner with Aboriginal health services to deliver cost-effective, sustainable and culturally appropriate treatment.

There are many questions left unanswered on how to deliver high quality treatment to Indigenous populations. The most urgent is how we can effectively raise community awareness and get the message to remote communities that cataracts are a preventable and correctable cause of vision loss.

Coordination of the services funded by different bodies (Australian government, regional and private) is required to ensure there is no duplication of models. In October 2000, Right to Sight Australia launched Vision 2020 as part of a global campaign to eliminate worldwide preventable blindness by 2020.

Many organisations from different sectors of eye health (service delivery, research, education and community work) are involved in this initiative. In order for this goal to be realised, improvements must be made in the acceptability and accessibility of surgery to Indigenous communities.

Chantel Thornton
Foundation for Surgery Board member

"Cataracts are 12 times more common in Australia's Indigenous population than in the non-Indigenous population"

Curmudgeon's Corner

Toilets are an important illustration of inequality

There is one thing that really annoys me and that is public toilets. Now last month I may have offended the female readers by telling them that they cannot be curmudgeons. If so that is tough – get over it. We curmudgeons don't care about offending people. This month, however, my gripe may make them pleased, but on the other hand it might enrage them. If so, you know my response – tough!

It is not the dirtiness or smell of public toilets that gets up my nose. It is not the lack of availability when you need one or the immutable fact that the critical ones are always closed when the urge is most urgent or only open from 10am to 2pm weekdays. It is not the graffiti or the lack of toilet paper. It is the male/female discord.

Look at a typical male toilet – there will be six or so urinals and maybe two or three stalls. Next door will be a female toilet of similar dimensions, but there will be at most six stalls. Simply arithmetic tells you that this is not equal.

However, our study needs to look at anatomy and physiology. Female urinary anatomy is not designed for rapid action (or at least not with clothes on, but let's not go there). Male anatomy is perfect for hit and run (provided that the damned prostate is behaving itself).

But physiology must also be considered. Why is it that a group of females must go to the toilet en masse? They can't seem to manage by themselves. Do they have some sort of joint neural activity for proper detrusor function?

Look at any busy public place. There is always a line at the Ladies and none at the Men's. The blokes wander in and are out in 60 seconds maximum. The ladies are gone for two or three minutes at least. Now we need a properly designed study to accurately time the transactions. I would offer to do it, but fear for my reputation if I am seen outside a ladies loo with a clipboard and stop watch.

So come on ladies, forget about burning bras and glass ceilings. Start counting and timing and agitating for changes in building design and revisions to current toilets. Your sisters will love you for this. The blokes may not if they have to line up, but that is tough; get over it!

Research for *Research*

What does being a scholar & teacher mean?

Being a 'scholar and teacher' is one of the nine RACS competencies; one that has not received much attention. There is the need to flesh out what being a scholar and teacher actually means, and to work out what needs to be done to enable all of our surgical Trainees to attain it.

The current approach to scholarship training and assessment adopted by all of the surgical specialties is to specify research requirements that must be met by all SET Trainees. What is striking is the marked difference in those research requirements between the specialties.

Further, the requirements specify the research outputs that must be achieved by Trainees, but do not specify the knowledge, skills or attitudes that the process is designed to teach. Nor are the requirements embedded in a curriculum that specifies the learning objectives, educational methods and assessment techniques.

The Board of SET and the Section of Academic Surgery have agreed to review these research requirement policies. To do this a working party has been convened with a representative from each of the specialties.

It was recognised that three approaches are possible:

1) to continue with each specialty determining its own research requirements,

2) to develop a generic template for training in 'scholarship and teaching' by combining the best elements of each specialty's program, or

3) to start with a clean sheet to develop a research curriculum.

The working party has chosen the third option on the basis that an educationally sound approach is necessary, that some of the knowledge, skills and attitudes will be generic, and that some flexibility is desirable.

As a pilot the working party was polled on what knowledge, skills and attitudes a SET Trainee ought to acquire and the results were revealing. There was strong agreement on some elements, but a complete lack of accord on others.

The next step is to conduct a survey of all Trainees and surgeons to crystallise what ought to be included in a list of generic knowledge, skills and attitudes, and what could be considered optional. This is an important and necessary step in the development of a curriculum and your opportunity to influence this process.

As a Trainee or Fellow you can access the on-line survey at the following web address: www.Research Requirements InSurgical Training.org.nz – a link will also be provided via the Fax Mentis e-newsletter. The results of the survey will be published in a subsequent edition of Surgical News. We are very grateful for your help and thank you for your participation in this important College-wide review of research training.

John A Windsor

Chair, Section of Academic Surgery

MORE PICS FROM THE ASC

Photos courtesy of John Aloysius Henderson.

Clockwise, 01: Mike Hollands; **02:** Richard Barnett, Keith Mutimer; **03:** Pam and John Henderson; **04:** Exhibitors Cook Medical Jenny Green, Lisa O'Bryan, Lisa Lober, Anne Berkelmans; **05:** Wendy Graham, John Graham, David Watters, Graeme Richardson; **06:** Pam Craig and Tony Buzzard; **07:** Campbell Miles, Vivienne Miles and Brian Morgan; **08:** Paul Beeson, Ian Civil, Ian Laurance and John Quinn; **09:** Jane Hollands, Mike Hollands, Cathy Ferguson, Graeme Campbell, Paul Cohen and Cynthia Cohen. Middle: The College stand.

In Memoriam

Our condolences to the family, friends and colleagues of the following Fellows whose death has been notified over the past month:

William Utley,
NZ Urologist

Peter Packer,
WA Otolaryngology surgeon

Hamilton D. Black,
NZ Orthopaedic surgeon

William Laister,
Qld Orthopaedic surgeon

We would like to notify readers that it is not the practice of *Surgical News* to publish obituaries. When provided they are published along with the names of deceased Fellows under In Memoriam on the College website **www.surgeons.org** go to the Fellows page and click on In Memoriam.

Informing the College

If you wish to notify the College of the death of a Fellow, please contact the Manager in your Regional Office. They are

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NZ: Justine.peterson@surgeons.org
QLD: David.watson@surgeons.org
SA: Susan.Burns@surgeons.org
TAS: Dianne.cornish@surgeons.org
VIC: Denice.spence@surgeons.org
WA: Angela.D'Castro@surgeons.org
NT: college.nt@surgeons.org

Helping people back to work

Forthcoming Industrial Medicine factory visit program

In all industry visits, participants have the opportunity of seeing work in action and seeing and exploring options for workers and management in return to work.

What past participants have said:

- ✓ "An extremely invaluable experience with regard to the workforce and measures taken by industry to minimise injury."
- ✓ "Practical and useful. Need to spread the word to others; physios and hand therapists."
- ✓ "Very interesting tour to see the work situation."

Victoria industry visit: Melbourne on Friday, 21 September, 2012, is the site of the next whole day visit (TBA). Two site visits promise to show a considerable variety of factory and other work performance and issues.

AOA/RACS Annual Medicolegal Conference: From Friday, 23rd of November, 2012 to Sunday, 25 November, 2012. The industry visit component of the program is on the Friday morning, visiting several CBD building sites. Participants have the opportunity to view the construction process from holes on the ground, through construction of the buildings to the finishing trades.

Proposed 2013 program: Planning is commencing for industry visits to National industry/employers represented in each state and territory to improve the opportunity for surgeons in those regions to participate in the program. As at present, the industry visit will comprise a whole day on Fridays which our surveys have shown to be popular and which enable surgeons to visit interstate if desired.

Edward (Ted) Schutz, FRACS
Convenor Occupational Medicine Bridging Course for Surgeons

For further information, please call +61 3 9249 1106 or email PDactivities@surgeons.org

Poison'd Chalice

The silence grew

"Be great in act, as you have been in thought"
(King John Act 5, Scene 1)

We were in the middle of the M and M meeting talking about our refugee from a South Asian country whose brief time in Australia had ended in a medical and surgical disaster beyond our grasp. I had highlighted the case in my previous epistle of *Surgical News*. His haemorrhage unable to be stopped, oesophageal varices beyond repair.

The shared grief in the room was palpable.

Part of me just wanted to 'gloss over' it. Just avoid this moment of shared pain. I looked hesitantly around the room and thought of the words, "I will be respectful of my colleagues, and readily offer them my assistance and support." The eyes that did meet mine were reflecting my internal turmoil.

The words of Hamlet Act 3, Scene 4 came to mind, "Assume a virtue, if you have it not'." I am not renowned for my 'soft side'. One does not become a "fearless" Director of Surgery by portraying softness all that frequently – particularly with other surgeons.

"I think we need to discuss how we are all feeling about this," I said. "This is one of the saddest cases we have discussed here for a long time." A tragic outcome, made worse because of the young age of the patient. Almost nothing would have assisted in the treatment. We were almost powerless to stop the outcome. But this man's last moments would not have been wished for by anyone.

People shifted in their chairs. They were not used to M and M meetings like this. A quick dissection of coroner reports if needed, an analysis of infection rates or the latest dramas about Prostheses companies. Then off to the cafe for coffee.

My registrar who was doing the presentation was looking at me. The words of "you have got to be kidding – Professor Kidding" almost telepathically pounding across the room. But she surprised me, or perhaps she didn't. "Well to be honest", she said, "I feel like shit."

"All the training and technology that we have was of no benefit to this poor guy who had survived death camps, refugee camps, as well as our government's hostile assessment processes. He seemed to have finally made it; to then have him die in front of us all was so unbelievably bad. At the end, the look in his eyes was a mixture of comprehension and incomprehension – he knew he was dying, but he just couldn't understand why."

I looked around the room for someone else to contribute.

We always have our nursing staff at these meetings. They are used to debriefings and counselling provided by the hospital after traumatic outcomes – why is that we have never offered this to surgeons, who after all, have to carry most of the weight of bad outcomes? Are we trained to just grin and bear it, deal with it internally, either become hardened to the point of caring less or being just a little more burned? Or do we just think psychological counselling is pointless, a waste of time that we don't have?

The charge nurse of our ward was there and stated the obvious – "I think you guys need to work it out, that everything we could do was done. And if you are thinking of having a group hug, let me know so that I can leave the room!"

Well that kind of put an end to the discussion, but I was still left with a feeling of incompleteness, as if I had missed something – maybe it was opportunity.

As we walked to the staff cafe for our coffee, I reflected on my registrar time in the UK at a London teaching hospital. It had been equipped with its own 'pub' – a cosy in-house bar where all the surgical staff would gather at the end of the day, triumphs and disasters shared, it was a place where it was okay for surgeons to share the stresses, to get both support and perspective. At the time it seemed an anachronism, a throw back to a bygone age. But now many years later, I wonder if it didn't serve a purpose.

Of course it is all gone now – a victim of 'political correctness'. As we reached the cafe, I announced: "the coffees are on me and let's have some jam donuts as well." I know I should have offered sushi as a 'politically correct' alternative, but stuff it!

Professor U.R. Kidding

Attracting the best for research

There is more room for growth to encourage young surgeons in the pursuit of knowledge

The record attendance at this year's Developing a Career in Academic Surgery (DCAS) Course was cause for cautious optimism, but the College and profession still must address significant challenges if more young surgeons are to be attracted into an academic career, according to Chairman of the Section of Academic Surgery (SAS) Professor John Windsor.

Professor Windsor said that the DCAS Course, a joint initiative with the Association of Academic Surgery in the US and held the day preceding the ASC in Kuala Lumpur, this year attracted 120 registrants including Fellows, Trainees and medical students.

He said that while the course was proving a success not only in its ability to attract registrants but also highly acclaimed academic surgeons from the US, much still needed to be done to train Australian and New Zealand leaders in surgical research.

In particular, he said rules that worked to limit the time Trainees are able to devote to research during their clinical training needed to change, specialty-specific research requirements needed to be raised and standardised and more money sourced to fund surgical research.

The Section of Academic Surgery was formed in 2002 and now has 140 members from Australia and New Zealand and there has been a three-fold increase in the past five years. Professor Windsor said, however, that with 22 per cent of College members having some affiliation with academia, there was plenty of room for more growth.

"The turn-out for the DCAS course and the rise in the membership of the SAS are both very encouraging, but we still have a long way to go," he said.

"I believe it is vital that we promote the training and development of academic surgeons, who combine research, teaching and clinical practice in their careers. Surgery needs those who are committed to research and evaluation and those who are committed to training the next generation.

"The very first president of the RACS made it clear that he believed the central role of the College was both to train surgeons and to promote surgical research, yet while we are well recognised for the quality of our training we could do more in achieving the second."

Professor Windsor, who directs the Surgical Research Network and is Professor of Surgery at the University of Auckland, said the aim of the SAS was to promote academic surgery.

He said a working party of representatives from each specialty was now looking at the research requirements of all Trainees to standardise the required competencies.

"There is great variability in research requirements across specialties and this may need to change," he said.

"Some specialties only require the acceptance of a poster at a conference, for instance, and I think that is demeaning both to Trainees and the profession.

"We are also looking into how we can encourage and support Trainees and Fellows wanting a career in academic surgery and as such we are investigating the system established in the UK 10 years ago that offers Trainee surgeons a parallel research training program while they learn their clinical skills.

"The turn-out for the [Developing a Career in Academic Surgery] course and the rise in the membership of the [Section of Academic Surgery] are both very encouraging, but we still have a long way to go"

"Under this system, young surgeons don't have to choose one over the other and are offered greater support, mentoring, flexibility and financial security while they build their skills in both surgery and surgical research.

"In the Surgical College we still have requirements that use such words as "interrupted training" and we still have rules about how long a Trainee can step away from clinical training to take on research which both send a negative message.

"I think this makes some younger surgeons somewhat wary of taking on a PhD because they are not sure the College is fully supportive. We need to make it explicit that we don't think it's interrupted training, but rather valuable time taken to learn other skills relevant to being a surgeon."

Some of these skills are addressed in the DCAS course with attendees this year offered presentations on the writing of abstracts, how to submit manuscripts and select the right journal, writing grant applications and the gaining of ethics approvals.

Professor Windsor said the limited availability of research funds in both Australia and New Zealand meant that the College and profession had to find ways to attract external funding and to work with universities and research institutes to reduce overlap and inefficiencies.

He said the fact that few surgeons sat on research funding bodies because of their professional time pressures also had an impact on the funds available for surgical research.

"The great New Zealand-born physicist Ernest Rutherford once said: 'We don't have much money, so we'll have to think' and I think that applies to us," Professor Windsor said.

"It has been calculated that NZ has one-third the amount of research funding available in Australia, one-fifth of the UK and one-tenth of the US. This means that we must use what money we have as wisely as possible and go outside the usual sources to find more.

"Currently the College distributes $1.4 million to surgical scholars each year which is of great benefit to the students, but a drop in the ocean compared to the $150 million we would need to have invested if we were to approach the levels of some university endowment funds.

"The College Council recognises this and discussions are now underway into how more research funds might be sourced."

Professor Windsor said that he would feel the SAS had met its goals when 20 per cent of Fellows were members. He also sees the opportunity to help promote the training of surgical leaders and that this fits very nicely with the training of academic surgeons. He said that at present there was no pathway for training surgical leadership.

"I think surgical leaders will come increasingly through the pathway of academic surgery because they have the ability not only to work at a high clinical level, but to evaluate research, collaborate, teach, analyse data, lead multi-disciplinary teams and manage complex administrative requirements," he said.

"One measure of achievement for me would be when the question of what makes a successful surgeon is answered with the reply – one who has made a significant contribution not just to clinical practice, but also to surgical teaching and surgical research."

With Karen Murphy

Addicted to Beta-endorphins

How about a life-exercise balance?

Up down, up down, up down, just two more times, then a rest. My personal trainer was working me so hard and I found myself wondering why I, Doctor Double Be-gloved, should have subjected myself to being told what to do by someone 20 years younger than me. If only I had the motivation and will-power to do it myself without needing to be urged on by someone else. But I knew I'd never be here if I hadn't made an appointment, not with all the other competing demands of my life.

But how valuable is regular exercise, or irregular exercise for that matter? Some of the surgeons I know swim most mornings and then compete in great ocean classics at the weekends. Others run or cycle. They are up early in the mornings and exhibit tremendous discipline.

All doctors are expected to take an interest in their own health. Codes of Medical Conduct do not demand that they exercise, but they do demand that they take their health seriously.

The benefits include increasing energy expenditure and when combined with a sensible diet should result in weight loss, for those who are overweight. But exercise also makes us feel good, especially afterwards.

However, the drawback of daily exercise is that it is addictive and once hooked, you become dependent. If you don't do it your mood sinks pretty quickly until your next workout fix. Some people don't just exercise for good health, they do it beyond extreme.

That reminds me of Doctor Try-Athletic who recently came to see me for a medical. We got talking about times, time trials and events. Now Doctor Try-Athletic is one of those surgeons who compete as often as possible. Every training session is planned in the hope of improving personal bests. The watch is stopped at every red traffic light to monitor true running time not standing waiting for the traffic time. Doctor Try-Athletic hates missing a run, a swim or a cycle. That brings me to why I was consulted; it was on account of feeling totally depressed due to a stress fracture in the foot.

Doctor Try-Athletic is addicted to endorphins. Serum concentrations of endogenous opioids, in particular beta-endorphin and beta-lipotrophin, increase in response to both acute exercise and training programs. Elevated serum beta-endorphin concentrations affect mood and there is a phenomenon of exercise-induced euphoria. Exercise can alter pain perception, and moderates the secretion of stress-related hormones such as catecholamines, growth hormone, prolactin, and cortisol. Exercise is therefore good for blood pressure, though it achieves this by a multiplicity of actions.

Dr Try-Athletic carries no excess weight. But there are times when being too thin due to compulsively exercising becomes detrimental. Triathletes rarely have self-insight; it is their families that notice.

So how did I counsel Dr Try-Athletic who I wanted to motivate to try athletics less obsessively? I was hoping there would be insight, that the stress fracture would be perceived as an opportunity to live life a little differently, to relax a bit more, and recognise that what we are is not always about achieving, achieving, improving, improving, being exhausted, tired, fatigued and more exhausted. The treadmill of life can be harsh, especially when you risk losing your self-esteem when you dismount. I tried the approach that the body was sending a message, one that should not be ignored. That fitness cannot be equated with goodness, even if endorphins make you feel good. They often don't make the family feel good.

Dr Try-Athletic has a habit of mounting the same defensive arguments over and over again, just like a runner who follows the same secure route every day. I probed as innocently, but as firmly as I could asking whether the family could enjoy more of the Dr's time, whether without exercise the mood in the house might be improved, whether some jobs around the house might be more likely to get done, talk about something other than sport, whether time would be made available to play more with the kids.

Dr Try-Athletic will have to go cold turkey on the running anyhow. Fortunately nature has ruled that the fracture will not heal for six weeks or longer. I am hoping that, when on review in three weeks, the acute loss of endorphins and feeling of depression will be lifting and that there might even be a couple of kilos of weight gain which would make Try-Athletic all the healthier.

Now I, Dr Double Begloved must stop writing and make sure I plan my next appointment with a personal trainer.

Dr BB G-loved

Workshops & Activities

Professional development supports life-long learning. College activities are tailored to the needs of surgeons and enable you to acquire new skills and knowledge while providing an opportunity for reflection about how to apply them in today's dynamic world.

Keeping Trainees on Track (KToT)

24 July, Brisbane

This 3 hour workshop focuses on how to manage trainees by setting clear goals, giving effective feedback and discussing expected levels of performance. You can also find out more about encouraging self-directed learning at the start of term meeting.

Non-Technical Skills for Surgeons (NOTSS)

27 July, Sydney; 28 September, Brisbane; 12 October, Launceston; 12 October, Perth

This workshop focuses on the non-technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues.

Supervisors and Trainers for SET (SAT SET)

8 August, Sydney; 15 September, Wellington; 26 October, Melbourne (AVSM – incl dinner)

This course assists supervisors and trainers to effectively fulfil the responsibilities of their very important roles. You can learn to use workplace assessment tools such as the Mini Clinical Examination (Mini CEX) and Directly Observed Procedural Skills (DOPS) that have been introduced as part of SET. You can also explore strategies to help you to support trainees at the mid-term meeting. It is an excellent opportunity to gain insight into legal issues. *This workshop is also available as an eLearning activity by logging into the RACS website.*

Surgical Teachers Course

14 to 16 August, Perth, WA; 18 to 20 October, Hobart

The two-and-a-half day intensive course enhances educational skills of surgeons who are responsible for the teaching and assessment of Trainees. Participants learn the foundation of improved educational skills, which are further developed during the course through practical application. The course is delivered through four main modules, which are integrated to achieve progressive acquisition of knowledge and skills.

Management of Acute Neuro-trauma

18 Aug Townsville, 31 Oct, Adelaide

You can gain skills to deal with cases of acute neurotrauma in a rural setting, where the urgency of a case or difficulties in transporting a patient demand rapid surgically-applied relief of pressure on the brain. Importantly, you can learn these skills using equipment typically available in smaller hospitals, including the Hudson Brace.

Preparation for Practice

25 to 26 August Melbourne

This two day workshop is a great opportunity to learn about all the essentials for setting up private practice. The focus is on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice and get tips and advice.

Leadership in a Climate of Change

14-15 September, Sydney

This two day workshop can help you to understand what it takes to be an effective leader in this century. It uses the DISC model (DISC stands for dominance, influence, steadiness and conscientiousness) to examine the nature and practice of organisational leadership, through the exploration of issues such as organisational communication, influence, power and styles of leadership. You can also learn more about working as a team and gaining team commitment.

DATES
JULY-OCT 2012

NSW

19 - 21 October, Sydney
Process Communication Model

NZ

15 September, Wellington
SAT SET

11 - 13 October, Wellington
Process Communication Model

QLD

31 October, Townsville
Management of Acute Neurotrauma

SA

18 August, Adelaide
Management of Acute Neurotrauma

TAS

12 October, Launceston
Non-Technical Skills for Surgeons (NOTSS)

18 to 20 October, Hobart
Surgical Teachers Course

VIC

2 - 4 August, Melbourne
Process Communication Model (Advanced)

25 - 26 August, Melbourne
Preparation for Practice

6 September, Melbourne
How Well Do You Know Your Practice? A Game Plan for Success

21 September, Melbourne
Occupational Medicine: Getting Patients Back to Work

17 October, Melbourne
Writing Medico Legal Reports

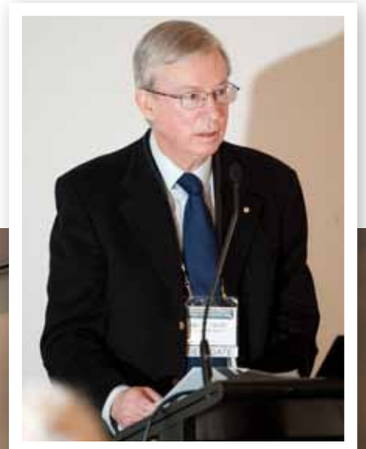
26 October, Melbourne
Strategy and Risk Management for Surgeons

WA

14 to 16 August, Perth
Surgical Teachers Course

3 September, Perth
Writing Medico Legal Reports

Contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit www.surgeons.org - select Fellows then click on Professional Development.



Below: Attendants at the 2011 Queensland ASM;
Inset: Speaker Geoff Davies at the 2011 Queensland ASM.

Advocacy, the Qld way

Interaction with the State Government in Queensland has been very successful in recent years

After two years as the Chair of the State Committee Queensland, I am in a position to reminisce a little. Recent comments by our new President pertaining to surgical advocacy remind me that in some ways Queensland has in recent years developed a strong consultative relationship with Government.

This relationship has been the envy of some of the other states I am told. My major role and that of recent Chairs in Queensland has been to represent the College at the interface between the practise of surgery and the State Government, in the expectation that such interaction will help to maintain or improve the quality of surgical teaching and the results of surgical intervention in both the public and private sectors.

There have been many obstacles, and the way in which the new regional health networks will affect our profession are yet to be realised, but the College has been involved at several levels in the process and we are not expecting any major problems. Queensland has been well represented on College Council in recent years having produced three Presidents in that time, Professor David Theile, Professor Russell Stitz and more recently Professor Ian Gough. The influence of those gentlemen and the many others who have supported them (three vice presidents and numerous councillors) has significantly improved the College's standing with Government.

There are multiple regular meetings with Government which include:

- The Surgical Advisory Committee Meeting – second monthly (three hours)
- Surgical Strategy Workshops – biannual (full day)
- QASM meetings second monthly (two hours)
- Queensland health forum – a full day as part of the Annual Scientific Meeting
- Queensland Clinical Senate
- Multiple other half day meetings annually.

"Such interaction will help to maintain or improve the quality of surgical teaching and the results of surgical intervention in both the public and private sectors"

The Chair of the Surgical Advisory Committee (SAC) has been a surgeon in recent years, Russell Stitz, who was replaced by Ian Gough, when he was appointed to chair the Lead Clinicians Group nationally. This group is attended by no fewer than eight surgeons on a representative basis, including orthopaedic, rural, and regional.

This group has in my view the greatest influence at this level and was, until recently, regularly attended by the current Director General, Dr Tony O'Connell. The meeting agenda includes all current advocacy issues and I have witnessed significant gains as a result. Government representatives take the meeting seriously, minutes are scrutinised by the Chair and brought to the attention of the Director General.

Surgical Strategy workshops are held twice a year, they are chaired by the Chair of the SAC and have an agenda agreed to by both parties. Directors of surgery from major teaching hospitals, representatives from the College, regional and rural, as well as representatives of multiple other surgical groups including operating theatre nurses and medical administrators all attend and debate is often robust. Russell Stitz has been an extremely capable and effective Chair. This forum is usually addressed by both the Minister for Health in Queensland and/or the Director General. The Chief Health Officer and one or more of the Deputy Directors General are in attendance.

Discussion and criticism

As part of the Annual Scientific Meeting (ASM) of the State Committee of the College in Queensland, we devote a full day (one of three) to an open forum with QLD Health. Presentations are prearranged in consultation with QLD Health, but ample time is devoted to discussion, and forthright criticism of our bureaucratic colleagues is taken in good humour – usually! This has become a fixed component of the ASM and is popular among surgeons. The ASM is at Stradbroke Island in August 2012.

The Clinical Senate in Queensland is a non-representative group which meets twice each year. The senate is chaired by Bill Glasson a former president of the AMA in Queensland and at national level. He is currently President of the "ophthalmology group nationally". Senators are all leaders in their respective fields and considered to be "movers and shakers". The agenda is not dissimilar from that of the meetings noted above. The executive of the Senate meets every two months and there is adequate surgical representation. Minutes are distributed to the Queensland state committee.

The Queensland Audit of Surgical Mortality is yet another committee which acts in conjunction with Government. Dr Jon Cohen was the first Clinical Director and through efforts beyond the call of duty established this Audit without precedent.

All public hospitals are now participating, but strangely none of the private hospitals in spite of the efforts of Jon Cohen and more recently those of John North the new Clinical Director. The reluctance of the private hospitals to be involved is peculiar and not mirrored in other states; however, there is the prospect for Uniting Health Care to be involved in the near future. We are hoping this will have a 'domino effect'.

The Northern Territory Audit is closely aligned with the Queensland Audit and combined meetings regularly take place. Russell Stitz is now the Chair of the Health Quality and Complaints Commission, the activities of which are in many ways complementary to those of QASM. Both groups are funded by QLD Health but while there is no immediate threat to that funding the likelihood of increased funding in the near future is remote. This may influence private hospital involvement.

It should be noted that the Statewide Trauma Network, under the mentorship of Cliff Pollard, Darryl Wall and Richard Lewandowski is also funded by QLD Health, however, that funding is certainly in doubt. This puts under threat the miraculous gains made in the coordination of trauma services in this vast state over the past few years.

Some political support will be necessary to protect this project in the very near future. The Trauma network and QASM will hold two major all-day workshops in Brisbane over the next few months. One is aimed at nurses and paramedics, the other at the medical fraternity, although registration is not exclusive of either group.

I was recently privileged to have been invited to a dinner to showcase the remarkable efforts of Professor Peter Woodruff in his leadership role with the Overseas Trained Specialist Mentoring and Upskilling Project.

The dinner was attended by the Director General, Chief Health Officer, and Deputy Director General. Peter a recent Vice President of the College, has been outstanding in this role and his forthcoming report will undoubtedly have a major influence over the assessment and mentoring of overseas graduates in years to come. At the dinner numerous overseas trained surgeons gave attendees an insight into their plight in both positive and negative respects.

Criticism was constructive, but it is clear we have a long way to go before it is plain sailing for this group of surgeons, if that ever eventuates. In a state so decentralised as Queensland we have a vested interest in the reality that very few local graduates have the inclination to practise in remote places and maintaining surgical standards in those places is both a challenge and a priority. Our sincere thanks go to Peter Woodruff for his diligent involvement in this QLD Health funded project.

Interaction with Government is at times frustrating, certainly challenging and occasionally rewarding. There are many opportunities for both younger Fellows and established surgeons to be involved in surgical advocacy which is an integral part of the role of the College and for me has provided an insight into the workings of our governing body at a grassroots level. It has been a privilege.

Maurice Stevens
Qld Regional Chair

Bravery awards for Urologists

Awards for bravery during the Christchurch earthquake were presented at this year's Urological Society of Australia and New Zealand's Annual Scientific Meeting

Medals made from the metal of a building destroyed in the 2011 Christchurch earthquake and designed by a New Zealand Urological Surgeon, have been awarded to four others for their outstanding courage and self-sacrifice in assisting victims in the hours after the disaster.

Called the Christchurch Medal, the awards were presented to the inaugural recipients at the Urological Society of Australia and New Zealand's Annual Scientific Meeting held in Darwin in April.

Almost 600 urological surgeons were attending the same meeting in Christchurch's city centre last year when the earthquake struck that was to claim 185 lives.

Many of those attending helped tend the wounded, but four surgeons risked their own lives to help rescue people trapped in damaged buildings.

They were Lydia Johns Putra from Ballarat, Brisbane based Stuart Philip, Stephen Mark from Christchurch and Julian Shah from England. All attended the Gala Dinner to receive the medal.

Dr Johns Putra was part of a team who performed a bilateral above-the-knee amputation to free a man trapped under concrete in a collapsed building in central Christchurch, shortly after the earthquake struck. With only a pocket knife to work with and at considerable personal risk, she crawled under tons of concrete to perform the life saving surgery in an unstable building that continued to be rocked by aftershocks.

Dr Stephen Mark provided medical assistance to the injured in the Arts Centre before searching for survivors in the collapsed Cathedral. He then went on to aid three people trapped on the top floor of The Christchurch Press Building. After accessing the roof via a cage suspended from a crane, Dr Mark entered the partially collapsed structure through a hole cut by the rescue team and despite continuing aftershocks, provided pain relief and support for several hours to two women trapped under debris until they were extricated.

USANZ President Stephen Ruthven presenting the medals to Stephen Mark and right, with Stuart Phillip.

Dr Stuart Philip from Christchurch originally, now based in Brisbane, demonstrated leadership, skill and courage in a precarious situation atop a destroyed building resuscitating, operating on and attempting to retrieve injured victims. According to the selection committee and medal citation, Dr Philip's communication skills, lateral thinking and organisational ability in setting up an emergency resuscitation and triage service made him invaluable to rescue efforts.

Mr Julian Shah assisted in the rescue of a woman trapped on the top floor of the severely damaged Christchurch Press Building. The last two flights of stairs had been reduced to rubble and after negotiating his way on his hands and knees, he assisted the trapped and severely injured victim until she was freed from under a beam and transferred to a crane rescue bucket. At that moment, a severe aftershock further damaged the stairs and upper floors leaving Mr Shah and his fellow rescuers with no choice, but to jump onto the roof of the adjoining building – a gap of 1.5 metres, five stories above ground.

Pride in courage

Urological Society President Dr Stephen Ruthven said "it was a privilege to honour the four surgeons for their great courage and self-sacrifice".

"These surgeons all have quite different personalities, but they were united by that one aspect of extraordinary courage," he said.

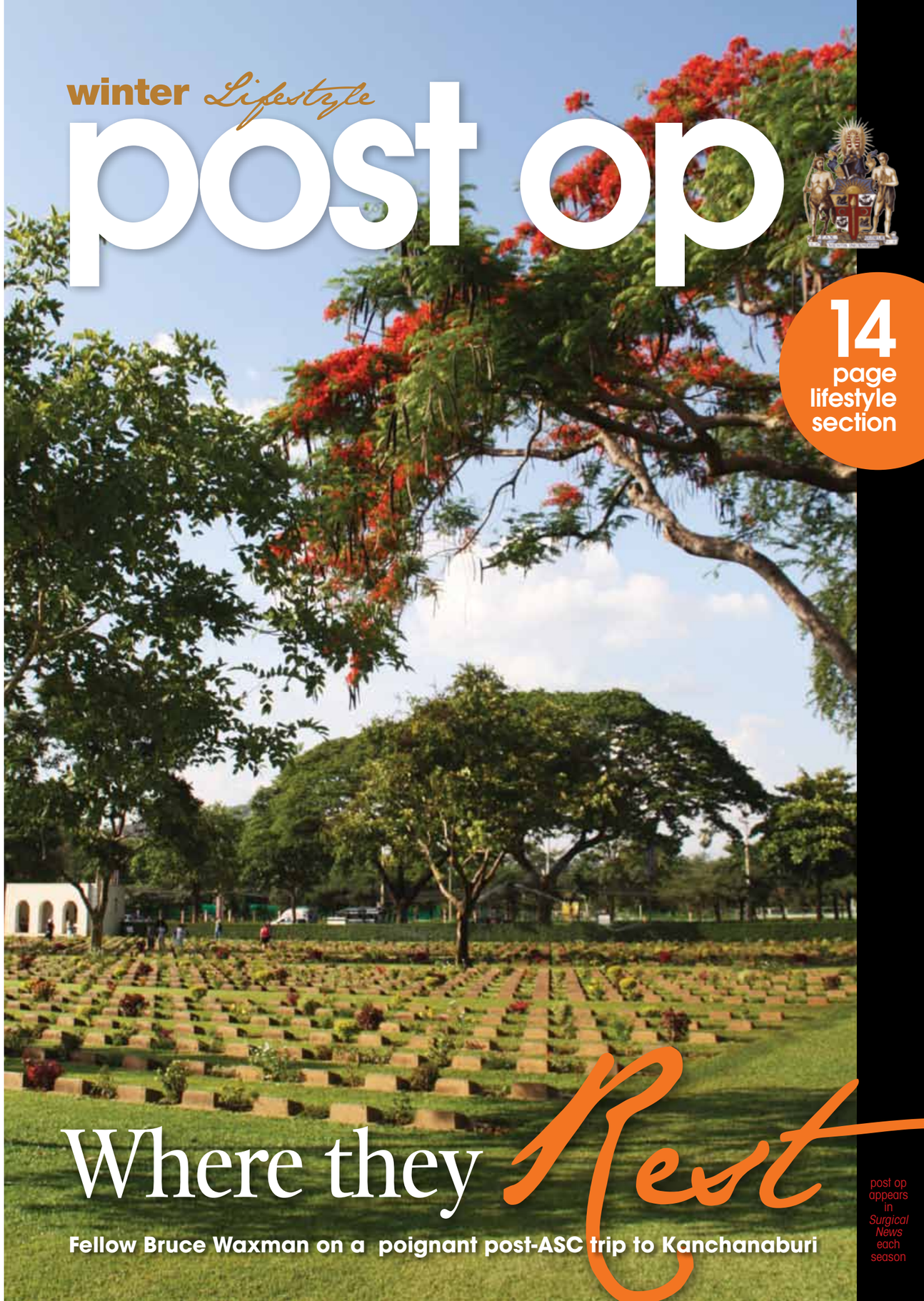
"It was a delight to have them all at the Gala dinner where they spoke freely about their experiences, all of them believing that their efforts were simply those of ordinary people who find themselves in extraordinary situations.

"It was also wonderful to be able to present them with medals that were made from the copper from the Crowne Plaza building, where many surgeons were staying for the conference, and designed by NZ Urological Surgeon Dr Stuart Gowland."

Mr Ruthven said "that while 50 medals had been struck, he hoped it would be a long time before more were awarded for exceptional courage."

Rather, he said "the Society had decided the best way to show respect to the people of Christchurch in recognition of their courage, loss and community strength was to also award it to Urological Surgeons who had made an outstanding contribution to society outside the profession."

With Karen Murphy



Remembering them

Left, Thai-Burma Railway Centre museum and Kanchanaburi War cemetery;
Above: Surgeons of Tour Group at Hellfire Pass with Rod Beattie holding sleeper and spike

Preserving our legacy – the Thai-Burma Railway and war memorials – should we be doing more?

Most of us either have a relative or loved one who paid the ultimate sacrifice serving Australia in war and whose remains lie buried in one of the Commonwealth War Graves cemeteries in Europe, Asia, South West Pacific or elsewhere.

For me it is my namesakes, both pilots with the RAAF, flying bombers over Europe in WWII, Bruce Williams and Philip Cawthorne, respectively the cousin and best friend of my father, Joseph, also a RAAF pilot.

Bruce lies in the Arnhem Oosterbeek War Cemetery, The Netherlands and Philip in the Becklingen War Cemetery, near Hannover, Germany. The Commonwealth War Graves Commission (www.cwgc.org) that manages these cemeteries ensures that the 1.7 million people who died in the two world wars will never be forgotten. They care for cemeteries and memorials at 23,000 locations, in 150 countries. Their values and aims, laid out in 1917, are as relevant now as they were almost 100 years ago

Bruce and Philip were therefore, very much on my mind when I visited the Kanchanaburi War Cemetery, on the River Kwai, 129 km north-west of Bangkok, Thailand in May 2012.

Here lie 6981 British, Dutch and Australian war dead, who perished constructing the infamous Thai-Burma railway. Having given the Albert Coates Memorial Trust (www.albertcoates.com) Oration in Ballarat in 2010, I was also keen to get a first-hand account of the challenges Coates and the other surgeons and medical officers faced coping with the atrocious conditions in this area. It should be remembered that Coates was the senior medical officer on the 'railway', to whom Weary Dunlop was responsible.

I was part of a group of 21 Australian and New Zealand surgeons and their partners on a tour organised by Philip Sharp, Chair, Surgery History Section, RACS and coordinated by HRG Events, after the ASC in Kuala Lupur.

The objectives of our tour were to visit the memorials and historic sites commemorating the sacrifices of the allied prisoners of war (POWs) on the so called 'Death Railway' and better understand the Thai culture in an atmosphere of collegiality and conviviality.

We achieved these objectives with visits to: the Bridge on the River Kwai and memorial; Kanchanaburi War Cemetery and the Death Railway museum; Hellfire pass and museum; Boon Pong's store and memorial in Kanchanaburi and the Weary Dunlop museum at the Home Phe Toey resort on the river Kwai, intermingled with good Thai food, entertainment and warm hospitality.

Although construction of the Thai-Burma railway began in June of 1942, it was conceived and designed possibly as early as 1937. The requirement to service and supply the Japanese forces then occupying Burma was the principal reason for the railway.

Initially it was intended that it would take some five years to complete, but circumstances demanded a much more rapid construction. The availability of some 60,000 intelligent, fit and disciplined allied POWs in Changi, Singapore and Indonesia, seemed an ideal workforce solution to the Japanese.

Conscripted Asian labour provided another nearly 180,000 workers and 15,000 Koreans and Japanese completed a workforce of just over a quarter of a million

The hard build

Building began in June 1942 with two labour forces, one based in Siam (Thailand) and the other in Burma (Myanmar) working from opposite ends of the line towards the centre.

The celebrated Bridge on the River Kwai was completed in August that year. Hellfire Pass was started on Anzac Day 1943 and five months later in October 1943 the 424km railway was opened, when the two ends met at Konkiota.

The opening was brought forward by the inception of the 'speedo' project which intensified the work, doubling the number of shifts to two of 12 hours per day. The monsoon was at its worst, cholera, malaria, malnutrition and tropical ulcers took a severe toll on the men. August of 1943 saw more than 1600 prisoners die on the railway.

Hellfire Pass with segment of railway

Below: Peter Sharwood, Rod Beattie and Peter Byrne in the streets of Kanchanaburi

Prisoners were paid wages for this! It was a tiny sum and the Australians pooled their money to buy medical and other essentials. Surprisingly on receipt of information from the Japanese about this at the end of the war, the Australian government docked some of the returning soldier's pay by the amount they had received from their captors!

The Japanese also kept extremely detailed records about each and every allied prisoner of war. This information has been subsequently used to verify much of what happened.

Had it not been for the resourcefulness of the Allied medical officers and medics the statistics would have been even grimmer. Exemplified by Coates, Dunlop and others, they were not only skilled at their medical work, but powerful and effective advocates for the general well-being of the prisoners (www.pows-of-japan.net).

Adjacent to a diorama of a 'medical hut' in the museum at Kanchanaburi, is a plaque recognising the over 40 Australian and New Zealand medical officers who served on the railway.

The person who brought all this to light for us was our tour guide at Kanchanaburi, Rod Beattie OAM. Rod is manager for Thailand of the Commonwealth War Graves Commission, curator of the Thai-Burma Railway Centre museum – his own private enterprise – and founder of the Jack Chalker (one of the POW artists) gallery (www.btrma.org).

Rod is an Australian civil engineer by training with a family tradition in the military, including himself. He is intelligent and energetic with a profound knowledge of the geography, geology and history of the area. His knowledge of those interred in the Kanchanaburi War Cemetery is encyclopaedic.

With more than a little help from his Vietnamese wife, Rod has discovered, cleared, restored and catalogued a huge amount of the Thai-Burma railway. He has excavated a large number of sites and retrieved priceless artefacts some of which are now beautifully presented at his museum. He has done this mostly off his own bat with little if any support, he believes, from the principal countries whose men are buried in the environment of the railway.

As a special memento of our trip, Rod donated to RACS a portion of an original sleeper and spike he had recovered in his foraging along the railway.

Members of our tour group were impressed with Rod's commitment and the sacrifices made by Fellows of our College treating their POW colleagues and we believe our College and the Australian government should do all they can to ensure the preservation and maintenance of this extraordinary site.

Time for art

Gillian Dunlop entered a noted portrait of Hazel Hawke in this year's Archibald Prize

Dividing her time between her Sydney consulting suite, theatre and art studio, ENT Surgeon Dr Gillian Dunlop has become as well-known for her portraits as her surgery. Over recent years, her paintings have reached the final of the prestigious Archibald Prize for Portraiture (in 2004), the Blake Prize for Religious Art (in 2003) and won the People's Choice award at the Salon des Refuses (in 2006). The list of the luminaries she has captured on canvas includes the Governor General, Ms Quentin Bryce, the Governor of NSW, Professor Marie Bashir, the previous Governor of Victoria, Professor David de Kretser and former Head of the Australian Defence Force and Governor of Tasmania, Sir Phillip Bennett. This year, she entered the Archibald Prize with a diptych of the much-loved Hazel Hawke, now sadly suffering from severe Alzheimer's disease. Dr Dunlop talks to Surgical News about Mrs Hawke, the Archibald Prize and her new artistic interests.

Why did you choose Mrs Hawke as a portraiture subject?

I decided to do that after visiting the National Portrait Gallery in Canberra. I noticed that while there were two images of Margaret Whitlam on display there was none of Hazel Hawke. I thought she had a significant impact during her public life, that people from all walks of life warmed to her and that in many ways she was Bob Hawke's greatest asset; gracious, generous and warm. I wanted to try and capture those qualities and ensure that while she is no longer in the public sphere, she is not forgotten in the public mind.

Why did you choose to paint a diptych?

The rules of the Archibald Prize are that the subject has to be painted from life, which I did, but I also wanted to show her as she was during her time as a states-woman. Her family provided me with a photograph from 1991 and allowed me to visit her in the nursing home.

Was that a difficult decision for her daughter to make?

Hazel had wished to help bring the disease out into public discourse – she had decided after the initial diagnosis that she was willing to be the face of Alzheimer's disease – which showed immense courage and dignity. Even so, her daughter, Sue Pieters-Hawke, gave the matter a lot of thought over a fortnight before agreeing. For me, it was a great privilege to paint someone in such a vulnerable state.

What reaction did the artwork receive?

Most people who have seen it immediately asked after her, which is why the family called it "I'm Still Here". Almost everyone then shared a story of someone they knew suffering the disease, which I think would please her enormously. Hazel had wanted to open up discussion on Alzheimer's disease and remove its stigma.

How do you manage your time between your surgical practice and your studio?

I am very fortunate because I have an amazing team of people around me, including secretaries, anaesthetists and nursing staff. I think the secret is to delegate and trust. I tend to work four long days so that I can dedicate the others to my art. Even so administration and basic logistics – like taking my sculptures to the foundry – eat into that time.

What are you working on now?

I have been working on sculpture quite a bit of late. I am also painting several posthumous portraits. I initially hesitated to take them on because I like to get to know my subjects. But then I realised that many portraits from earlier times, in the Renaissance for example, were painted posthumously, in memory of the subject, with an artist lucky even to get to see the body lying in state. That idea made it seem a creative challenge.

visit www.drgilliandunlop.com.au

Experience into words

Paul Anderson has put some tense experiences into a novel

As a junior consultant working in a liver transplantation unit in Cape Town South Africa in the tense period preceding the dismantling of apartheid, Mr Paul Anderson was caught up in the chaos of a terrorist attack.

In an act designed to inflame racial hatred and jeopardise the peaceful transition of power to Nelson Mandela's African National Congress, members of the radical Pan African Congress stormed a mixed-race church in the city, firing weapons and detonating hand-grenades covered in nails into the crowd of worshippers.

Eleven people were killed in the attack, with 50 seriously wounded including Mr Anderson. He described the attack as horrific.

"Grenades which exploded blew off the limbs of some of the congregation," he said.

"The carnage and death toll could have been much worse, but for the fact that on that evening only one door of the church was open due to bad weather. The terrorists had planned to come in through the four doors of the church and set up a cross-fire to kill as many of the 1500 congregation as possible. Also fortunately on that evening one man in the congregation was a former police officer who had a gun and began firing back, which caused the terrorists to leave prematurely and significantly reduced the number killed."

Writing as therapy

In describing his own injuries, he said: "One bullet went through my side under the skin and one grazed my temple, but my main injury was caused by a grenade which fractured my arm in 14 places. The only thing that was intact was the nerve, vein and artery which was fortunate in a strange way as if those had been interrupted, I may not have ever been able to operate again."

A friend of his who was a prominent orthopaedic upper limb surgeon, worked on Mr Anderson for five hours, using innovative treatments for the time including titanium plate implants for which there was a significant risk of non-union. While one became infected and had to be removed, both the radius and the ulna in his arm healed and in three months he was able to operate again. Nine months later he was offered a surgical position at Flinders University in Adelaide, South Australia, which he accepted.

Paul Anderson on some of his trips with Specialists Without Borders.

Originally from New Zealand, Mr Anderson said that at the time he felt that as a typical laid-back Kiwi male he could put the horror behind him, but unable to sleep and having a hyperactive response to anything that sounded like a gunshot, made him realise that getting over the trauma may not be that easy.

"I went to a children's party with my son and found myself ducking at the sound of a popping balloon," he said. "While post-traumatic stress disorder (PTSD) had not been well defined, I knew I had been psychologically affected and needed to do something to change that. A friend suggested I write about the event as a form of catharsis.

"It must have helped because less than a year later after I had taken up the position in the Department of Surgery at the Flinders Medical Centre, I had a psychological evaluation which found no after effects of PTSD."

The 60 pages he wrote sat at the bottom of a drawer for 10 years until 18 months ago when a local film producer read them and felt the story had all the makings of a great film which inspired Mr Anderson to finesse, develop and fictionalise the original work to make it the backbone of a successful novel called Does it Hurt to Die?

Released earlier this year, the book is a medical mystery thriller which draws on factual events and a Ph.D. which Mr Anderson did centred on race and politics in South Africa.

His undergraduate medical degree was at the University of Cape Town/Groote Schuur hospital where the first heart transplant was performed by Dr Chris Barnard. His Ph.D. was through the Conservative Afrikaans University at Stellenbosch. He said this experience had allowed the novel to be historically correct and subliminally educational while developing an intriguing storyline.

What's it about?

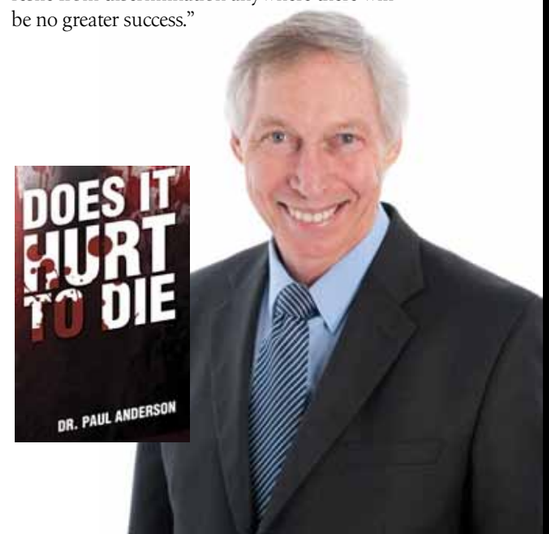
Mr Anderson said the novel followed the trail of a son who returns to South Africa from Australia to learn what happened to his father, a liver transplant surgeon, who was mysteriously murdered during the years of the apartheid regime. Finding a buried cache of documents in the grounds of the old family home, he discovers his father was also involved in secret genetic experiments based on notions of racial superiority. As the research contained in the documents still had relevance, the son ends up being pursued by members of the National Intelligence Agency and a secret white supremacist group.

Mr Anderson said there were serious underlying themes in the novel, mostly centred on racial abuse, corruption, prejudice and bad government.

"I was appalled at some of the treatment of people of colour in South Africa," he said.

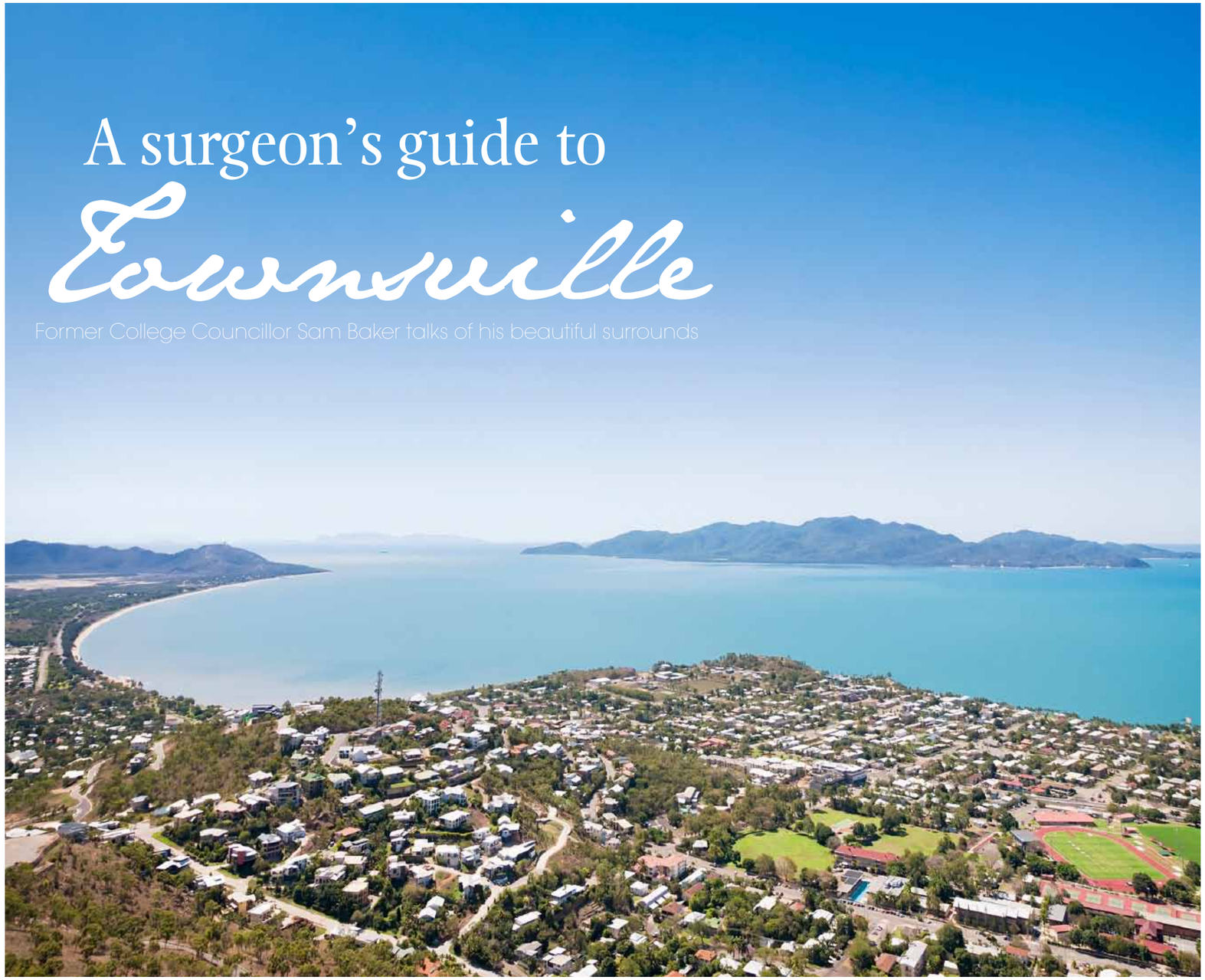
"This was a society which was so foreign to countries where there was no legal segregation. Some of the events demanded a retelling in a form that captured the imagination and contributed to history."

Asked what he hoped the novel might achieve, Mr Anderson said: "I hope that the book will allow the grotesque image of cruelty and inhumanity that is racial segregation to remain committed to history and if it makes one person resile from discrimination anywhere there will be no greater success."



A surgeon's guide to Townsville

Former College Councillor Sam Baker talks of his beautiful surrounds



Growing up in the small central Queensland town of Biloela with a constantly busy GP dad, former College Councillor and general surgeon Mr Sam Baker decided that if he did pursue a career in medicine, he'd do everything possible to ensure a better work-life balance.

And so he has.

Having arrived in Townsville 10 years ago after enjoying his time there as both an intern and registrar, Mr Baker established one of only two general surgery group practices now operating in Australia.

Comprising five general surgeons and breast and bariatric physicians, the group is known as North Queensland Minimally Invasive Surgery and was Mr Baker's solution to the workload pressures that often confront rural and regional surgeons.

With a special interest in advanced laparoscopic and bariatric surgery, Mr Baker is also the father of twin infant daughters and the husband of dermatology trainee Lisa, who currently commutes to Brisbane and Cairns to complete her training program.

"It was my idea to start the group because I thought it was the best way for all of us involved to have both a life and a career," he said.

"We encourage each other to take at least one month off each year for professional development and recreation so we can avoid burn-out and continue to enjoy our work.

"I watched how hard my father worked when I was young, when we hardly ever saw him, and I always thought it shouldn't have to be like that, but I think many people get stuck on a merry-go-round where they work extremely hard to establish their practice and then find it difficult to pull back.

"I've seen too many surgeons burn out, even as a registrar, and it seemed ironic to me that while we were working to restore other people's health and hopefully return them to a rewarding life, we were often doing so at risk of our own."

Mr Baker said the advantages of the group practice included the ability to offer the most advanced training to registrars available in the private sector, a one-week-in-five on-call roster and an outreach program that allows each surgeon to visit outlying towns to treat both private and public patients.

It also enables him to have a part time roster, working the equivalent of three weeks of every month so he can care for his daughters and support his wife during her training.

From 2008 to earlier this year, Mr Baker was also a College Councillor, a position he took to help tackle the challenges facing the medical system in the wake of the Patel scandal in Bundaberg.

"I became involved in the council after my time as Director of Surgery at Bundaberg Hospital before Patel arrived and became interested in medical politics because of the changes I believed had to be made to ensure nothing like it could happen again."

While Mr Baker admits that his young family is necessarily his consuming outside interest at the moment, he also has a liking for motor sports and last year completed the Targa Tasmania car rally.

Yet even if he doesn't have the freedom of earlier days, still he enjoys the beauty of North Queensland and Townsville in particular.

"We might have crocodiles and sharks and box jellyfish and nine out of 10 of the world's most deadly snakes, but that doesn't bother us or the tourists who love it up here," he laughed.

"Where I live, on the end of the Strand we have magnificent views and from my lounge room I look out over the water to Magnetic Island which is stunning.

"All the people who get stuck in the cities have no idea what they are missing."

But just in case you were wondering, here are Mr Baker's tips for enjoying the good life in tropical North Queensland. ▸

THE TOWN OF TOWNSVILLE: Situated on the Ross Creek and overlooked by the 290 metre high Castle Hill, Townsville has become the unofficial capital of North Queensland and one of the fastest growing regions in Australia. Boasting an average of 300 days of sunshine each year, it is located in the dry tropics with temperate temperatures ranging from 31 degrees in summer to 13 degrees in winter. First described by Captain Cook on his first voyage to Australia who named it Cleveland Bay, Townsville was not named such through a lack of imagination, but after one of the early maritime pioneers Robert Towns. Now with a population of just under 200,000, Townsville boasts beautiful seafront walks, elegant old buildings, a thriving CBD and nightlife precinct while also acting as a gateway to one of the world's great tourism attractions, the Great Barrier Reef.

HANG OUT IN HISTORY: The history of Charters Towers sounds like legend, but is actually fact. On Christmas Eve in 1871, a young aboriginal lad struck gold by chance when out prospecting with others at the foot of Towers Hill, sparking a massive gold rush. The thousands who poured into the town in search of that elusive Lady Luck, made Charters Towers for a time the second largest town in Queensland after Brisbane. With its streets still lined with glorious old buildings and an atmosphere still oozing its past golden history, Charters Towers combines the past with the present with craft markets and antique shops along with museums and the oldest surviving gold battery all tempting the traveller.

TAKE A DRIVE: An hour's drive north of Townsville will take you to the heritage-listed wet tropics region of Paluma Rain Forest and the quaint village of Paluma itself perched on a mountain top. Along the Paluma Range you can find both Little Crystal Creek and Big Crystal Creek, both of which are ideal for swimming, camping by permit or bushwalking. For the more motor-minded traveller, the Paluma region features as one of two trails forming the Great Tropical Drive, a self-drive touring route that winds its way from tropical beaches, to ancient rainforests and over the ranges to the outback.

TAKE A DIVE: One of the most outstanding wreck dives found along the Great Barrier Reef is that of the S.S. Yongala, a steel and timber steamship that sank during a cyclone in 1911 killing all 122 people on board in what was considered one of the most tragic incidents in Australian maritime history. Only discovered in its watery resting place 48 nautical miles from Townsville in 1958, the wreck is now an internationally regarded diving and tourism destination. Lying in the middle of a flat sandy shipping channel in about 30 metres of water, the wreck is covered in brightly coloured soft and hard corals, hydroids and sea fans while the rudder, aft, forward masts, engine and steam rooms and even most of the name can still be seen.

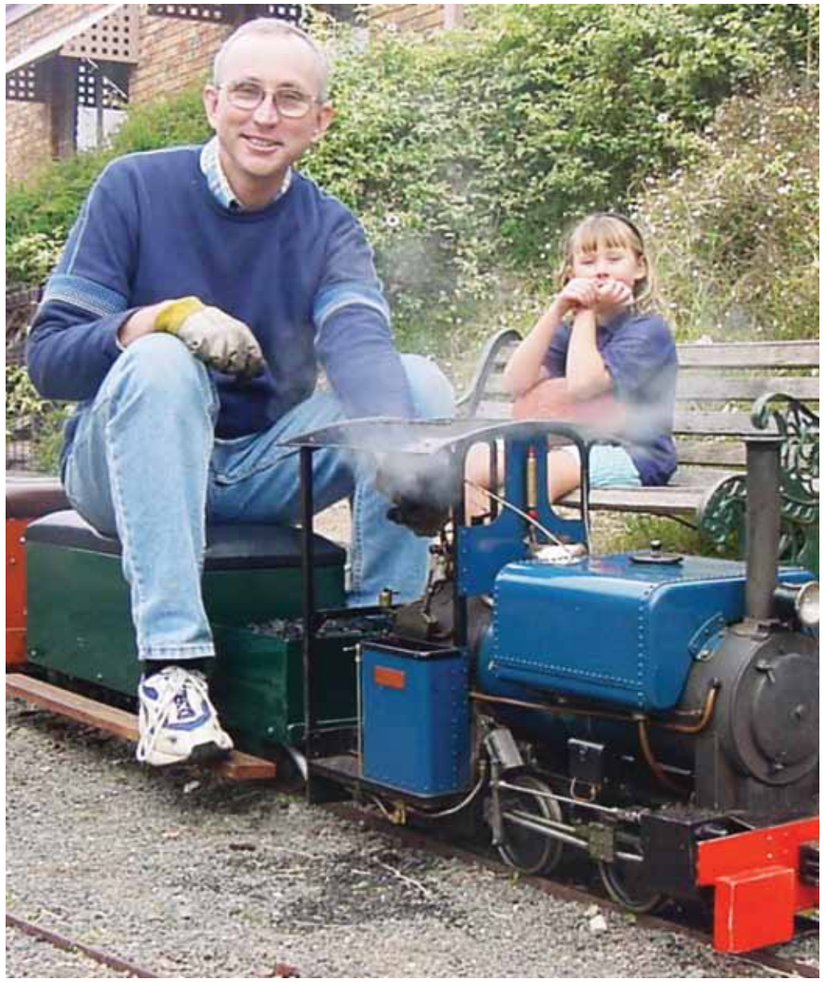
MODERN ATTRACTIONS: Back in town, check out the Strand, the Palmer Street restaurant district or hire boats to cruise the pristine waters of North Queensland. The Strand provides views to Magnetic Island and Cape Cleveland and while periodically destroyed by cyclones, it is always rebuilt and enhanced and today features parks, barbecue areas and a water-park. Townsville hosts a nightclub precinct around Flinders Street East while Palmer Street is the food focus, with restaurants offering cuisines from around the world using local seafood and produce. Mr Baker said: "Parts of Townsville, particularly Palmer Street and the nightclub district, have really come of age in the past 10 years so we lack for nothing now in our tropical paradise."

AN ISLAND PARADISE: Known to the locals as Maggie Island, Magnetic Island offers superb walking tracks through lush bushland with stunning views of the coast for the more sedate with horse riding, sea kayaking and seaplane jaunts for the more wild at heart. A world heritage listed island, it is half an hour off the coast of Townsville. Feed the lorikeets or rock wallabies, hire a 4WD, get away from absolutely everything and go fishing or find your own deserted beach far, far from the madding crowd. Said Mr Baker: "It's the best island off the coast from Townsville with beautiful beaches and bays, great wine bars and restaurants and it's a relaxing weekend destination for locals as well as tourists".

With Karen Murphy

Regional Fellow Graeme Campbell puts his hands to good use in his spare time

All aboard!



With a virtual patient catchment area, thanks to modern technology, stretching from the bustling central Victorian town of Bendigo to Mildura in the West, Mr Graeme Campbell is an extremely busy general surgeon.

With a special interest in developing regional breast and colorectal cancer treatment systems and recently as President of General Surgeons Australia, a College Councillor and Chairman of the RACS' Professional Standards Committee, Mr Campbell treasures what little free time he can find.

When he does, however, chances are he can be found in his garage building, up-grading or maintaining his model steam locomotives or electric train or taking them for a run around the track in his extensive back yard.

Yet these are not dinky little toys. Rather, the steam locomotives are miniaturised models of the glorious old behemoths that drove the industrial revolution. Each one weighs 50 kilograms, is fired by modified brown coal and can pull six to eight adults comfortably.

With their own names, Moyne and Bluetit, their own shed and their own 75 metre back yard track, Mr Campbell's train set appears to emerge straight from a delightful childhood fantasy.

"My father had a model stream train in the back yard when I was a lad and I used to work on that with him," he laughed.

"Now I have a British dock-shunter locomotive, a model narrow-gauge steam locomotive and an electric train that I built eight years ago with my own son.

"I did all the metal work for that one with the lathe and milling machine in my workshop and wrote all the details of how it was made for publication in Australian Model Engineering.

"That one runs on a 12 volt car battery and has two electric motors driving the chains under the wheels and is similar to a sugar cane train that you would see in Far North Queensland.

"That was an extremely enjoyable experience, was quite challenging and took about 200 hours to build, I'd estimate.

"I also have another one that I call Toby the Tram Engine that is designed to be safe for a five-year-old to drive, but still, even that one can pull two adults."

Mr Campbell said he first took up the hobby not long after arriving in Bendigo, having done a portion of his training in rural Victoria and deciding that the patient mix and lifestyle offered in a regional setting were to his liking. And though there has since been a resurgence of interest in the field, then, if he wanted a certain component or style of train he had to build it himself.

"When you're a surgeon with a busy on-call roster you need a hobby that you can do at home," he said.

"You can't go too far afield, you can't really get involved with activities where other people are depending on you and you need something that you can take up and put down.

"I found model train building met all the criteria. I, as with many surgeons, like working with my hands, I like the challenge of problem solving and after we bought the house block next door, I had the space to build the track which took hours of contented work to build and involved 4000 separate welds."

With his children now adults, Mr Campbell said he sometimes let the neighbourhood kids take a peek, many of whom had been alerted to the treasures behind the fence by the full-size rail semaphore signal staked proudly in the yard.

Sometimes too, they will even get to see the HO double garage-sized train set mostly of Victorian model prototypes located in the garage.

"I put in all the electronic decoders in the locomotives, did all the work on the tracks and made the models of Victorian goods carriages," he said.

"I didn't start out with a particular station or geographical location in mind when I began, but it is certainly somewhere in Victoria now."

In his professional life, away from the tracks, Mr Campbell works out of Bendigo Health, the St John of God Hospital Bendigo, Castlemaine Health and the Bendigo Day Surgery. ▸

Yet his sphere of influence spreads much wider.

As a general surgeon with an interest in the design and delivery of cancer treatment systems for rural patients, he conducts teleconferences with colleagues in areas as far afield as Mildura and Swan Hill and co-ordinates surgical outreach services for outlying districts.

"In recent years there has been a push to regionalise the treatment for the most common cancers because it had become so obvious that patients do better if they can be treated in their home region and not asked to travel back and forth to the city for tests and treatment," he said.

"That means that medical oncology and radiation oncology have to be regionalised with outreach and video-conferencing provided to link surgeons and specialists in more distant towns and regions.

"We have now done this in Bendigo, meaning that we can now offer the best multi-disciplinary care available, but in a regional setting which is a great achievement."

To act as a balance to all his professional commitments and committee memberships, Mr Campbell is also a member of a model train club called the Steam Locomotive Society of Victoria, located in Moorabbin, Melbourne, which has its own extensive track system and which holds monthly runs for the pleasure of the public.

He also takes his trains occasionally to steam around the beautiful park-based model train track in Wagga Wagga, NSW.

He even takes train journeys and has ridden the steam trains of Wales and Scotland and next year plans to travel by train across Canada.

"I like the chance to mix with other people outside medicine," he said.

"It's enjoyable to discuss problems and solutions with others, to see what others have made and share an interest with people both here and overseas.

"I can't stress enough how important I think it is for surgeons to have an interest outside the profession. I have known a lot of surgeons who never found something they enjoyed doing outside their work and the approach of retirement loomed very large.

"That won't happen to me. I'll just think up something new to build.

"For me, there has always been something peculiarly fascinating about steam trains.

"They are always feminine and they almost feel alive, as if they are talking to you. You can hear them breathing and you can tell when they are puffing along happily or are toiling or labouring.

"Their working parts are on the outside where you can see them and that's interesting and pleasing, I think, to modern eyes. When you're driving one you have to keep the fire burning, you have to keep the water levels right and keep check of the pressure and it is a very satisfying, rather complex endeavour." ●

With Karen Murphy

Corruption, Integrity, Ethics & Us

Datuk Paul Low, President, Transparency International Malaysia, gave the George Adlington Syme Oration for the Convocation of the Royal Australasian College of Surgeons at the 81st Annual Scientific Congress in Kuala Lumpur on May 6, 2012

That oration is repeated below.

It is indeed a great privilege and honour for me to be invited to deliver the George Adlington Syme Oration at this congress. Representing Transparency International Malaysia (TI), a non-governmental organisation whose main purpose is to combat corruption and promote integrity and good governance, it is therefore appropriate for me to speak on corruption, integrity and ethics.

The subject of corruption, integrity and ethics have been important issues throughout the history of mankind because how much we know about them, and how we define, pursue or practice them impacts our personal lives and that of others. And each of us, as individuals, and collectively as a society, could have profound influence on the way we all live, work and build a nation or a civilisation.

For example, the Arab Spring uprising is a manifestation of failed states, failed leadership, failed institutions, and the root cause of these failures, I believe, can be traced to the failure in dealing with corruption, failure in observing principles of integrity and failure in governing on sound ethical values.

The current crisis in the Eurozone, starting with Greece, while being economic in nature, is also rooted in issues of corruption, integrity and ethics. The rot of corruption has taken root even in the most basic provisions of public services such as the public health care service where government doctors are demanding extra payment from their patients for services which are meant to be provided for free by the State.

The same can be said of the financial crisis of 2008 which caused the collapse of large global financial institutions like Lehman Brothers and others, the consequence of which caused many ordinary people to lose their lifesavings. A new era of awakening has arrived in people's activism with "Occupy Wall Street" protesting against those in power and influence as well as protesting against institutions perceived to support the manipulation of markets in the guise of deregulation – all fed by unbridled greed, giving rise to inequitable distribution of wealth.

It is a failure of the type of capitalism which we practice today, unfettered by any sense of righteousness and absent of any guidance of a moral compass and good conscience of practitioners.

Foremost, let me touch on the subject of corruption.

Corruption

Most people have a very simplistic view about corruption. This is the main reason why the fight against corruption is often directed mainly through enforcement and less through prevention. People often see corruption as a lesser crime, accepting corrupt practices as the way things are, with some even considering it a necessity to facilitate transactions.

In a broad sense, Transparency International defines corruption as the abuse of entrusted power for personal gain or benefit. It is an economic crime because it is, by nature, similar to extortion and stealing. It is also the primary enabler of organised crime.

Corruption does not occur in a vacuum and, when it becomes systemic, it causes either directly or indirectly, many other social ills and injustices in society such as violence, poverty, human rights abuses, authoritarian and oppressive regimes, environmental destruction and also prolonged political and civil conflicts and wars. Ultimately, it impairs social and economic development, leading to the creation of failed states, examples of which I have cited earlier.

On a grand scale, corruption is an enabler of state capture whereby people in position of power form relationships with other interest groups (such as businesses and organised crime) to undermine the proper functioning of institutions (such as enforcement agencies and the judiciary), administrative processes and policies to favour themselves, their relatives or their political supporters so as to gain financially from state resources.

On a personal basis, each of us, to a certain degree, are entrusted with powers, both explicitly by virtue of the positions we hold, and implicitly by the profession which we belong to. Entrusted powers in the hands of someone with no regard for integrity is highly dangerous.

Integrity

What then is integrity? We know that is the value or character traits almost all persons think they have, except maybe for those who are already in jail. Many may not understand what it is, but few will accept being described as lacking in integrity. The lack of it means that we are not truthful, we are dishonest and the implication is that we cannot be trusted. It can also mean that we are inconsistent; we practice double standards and are hypocritical.

Integrity can be defined as being committed and being steadfast on righteousness, regardless of the circumstance.

Firstly, it requires an unwavering commitment to do what is right in spite of what it might cost us. It is based on a personal conviction, displayed in our behaviour and in how we live our lives. Many would uphold integrity only until it involves a personal sacrifice and only until the personal costs becomes too high.

But this is not so for two persons who were awarded the TI Integrity award in 2010: Attotage Prema Jayantha is better known to Sri Lankans as Poddala Jayantha, his pen name during two decades of courageous investigative journalism. Refusing to turn a blind eye to corruption, Jayantha dedicated his career to fearlessly exposing injustices in Sri Lanka's health, education and transportation sectors. One of his reports uncovered what some officials have called Sri Lanka's biggest ever tax scam, involving the alleged misappropriation of RS 3.6 billion (US $37 million) in Value Added Tax.

Following numerous threats on his life, Jayantha was abducted by unidentified assailants in June 2009 and brutally beaten. He was left permanently disabled and now lives in exile. No arrests have been made and the case has since been dropped. Jayantha's pursuit of the truth resonates with journalists who encounter such challenges to their work in many parts of the world.

Sergei Magnitsky's commitment to integrity ultimately cost him his life. A Moscow-based lawyer, Magnitsky was representing US investment firm Hermitage when he bravely agreed to testify against senior Russian officials, accusing them of using Hermitage-owned assets to fraudulently reclaim US $230 million in taxes.

In November 2008, Magnitsky was imprisoned on charges of conspiracy. In pre-trial detention, he developed acute health disorders, but was reportedly denied medical treatment.

Despite suffering excruciating pain, Magnitsky persistently refused to withdraw his statement. He died almost a year after being jailed. An official inquiry launched in 2009 resulted in the dismissal of a number of senior prison officials. The initial tax fraud case was never concluded, but the unbreakable strength of this one individual will never be forgotten

Secondly, integrity acknowledges that there is an absolute standard of right or wrong, existing independently of our own emotional experiences and preferences. Without an absolute context, the word "integrity" conveys no meaning to us. Having differing definitions of morality and righteousness, it would be a vague assertion of political correctness or popularity.

As CS Lewis said " Whenever you find a man who says he doesn't believe in real right or wrong, you will find this same man going back on this moments later. He may break his promise to you, but if you try breaking one to him, he will be complaining "it is not fair".

In a post-modern society where relativism of truth dominates our thinking, having a standard of absolute truths becomes difficult. Truth is necessary to provide what is acceptable and what is not. It requires boundaries to be defined and set, and it requires its compliance to be monitored and regulated if necessary.

We need ethical values to be defined because humans have the propensity to do bad rather than good.

Ethics

We need moral principles that would a form a guide to human conduct with respect to what is right and what is wrong, whether in our actions, our behaviour or our motives. Such a guide may apply to a particular set of human actions or to a particular group such as a group of practicing professionals or even more broadly, to a culture.

As much as ethics refer to well-founded standards of righteousness that prescribe what humans ought to do, its determination is often difficult.

Some may argue that it is determined by what one feels is right or wrong. Feelings are subjective and may deviate from what is ethical. Neither is being ethical the same as complying with a set of civil laws. Although laws are formulated to include ethical values to which most citizens subscribe, they may not be ethical. For example, laws that legalise and uphold discriminatory practices or violate human rights and freedoms may not be ethical.

Being ethical is also not the same as what is accepted as the norms of behaviour of society. History has shown that an entire society, and by extension a civilisation, can become ethically corrupt. Nazi Germany is a good example of a morally corrupt society. Many nations have risen and fallen due to the decadence coming from not upholding moral values.

What then is ethics? Without having a definitive framework of ethics it would not be possible to know what corrupt practices are or what integrity is.

Firstly, ethics need well-founded standards of right and wrong of human behaviour in terms of rights, obligations, fairness, benefits to society and specific virtues. Secondly, it also needs standards that define boundaries and obligations. Thirdly, it needs to expound virtues such as honesty, compassion and loyalty.

Finally, as most of our behaviours do affect others in terms of our relationships, I believe in the guiding principle of being responsible for our actions and not being evasive of it - and in addition, loving our neighbour as we do ourselves. We would have integrity if we discern what is ethical, and acting on this, even at personal cost.

What about us?

How often have we taken paths that may be unethical? Codes of conducts, ethical rules, guides and regulations are there to give us points of references or benchmarks. They help to point out where we deviate, but compliance will depend on our will power to walk the path of integrity. This will depend on our own convictions, shaped by our conscience, and on us having the will power not to succumb to lustful desires of our hearts such as greed, unbridled materialism, acquisition of power and even the need for self-glorification.

People of integrity are consistently truthful. Their word is their bond, allowing their "yes" to mean "yes" and their "no" to mean "no". They don't say one thing and do another. They are genuine and authentic. There is no malice and deceit in their actions. They are straightforward, fair and even-handed.

They are respectful, helpful and gracious to anyone and everyone. They go the extra mile to serve others more than themselves, and they do more than is required of them. They are also peacemakers.

They walk the talk. What they do, matches what they say.

Finally, people of integrity are always willing to be held accountable for their actions. They don't blame others to save their own skin.

As the saying goes, "The man of integrity walks securely, but he who takes crooked paths will be found out sooner or later".

Be a person of good character. This requires humility to accept, and to intentionally change our mind-sets to focus on "whatever is true, whatever is right, whatever is pure, whatever is lovely and whatever is admirable and anything that is excellent or praiseworthy".

Thank you, ladies and gentlemen for listening to me.

Confidentiality

This article first appeared in the Spring 2011 issue of MDA's *Defence Update*. It is reproduced here with permission.

Doctors have an ethical, professional and legal duty to protect the confidentiality of the information acquired as a result of the management of their patients. This duty forms the basis of trust and honesty in the doctor-patient relationship.

It has long been recognised that a relationship of complete trust is essential for any effective therapeutic relationship between doctors and their patients. The duty of confidentiality encourages patients to fully disclose all personal information truthfully so that they can receive appropriate medical care.

Patients should be able to divulge information to their doctors without fear of embarrassment, harm or discrimination that may arise from the widespread dissemination of the information. The duty of confidentiality extends to all information that arises out of a doctor's professional relationship with patients. A patient's right to confidentiality survives the doctor-patient relationship and the patient's death, as stated in the World Medical Association's Declaration of Geneva:

I will respect the secrets that are confided in me, even after the patient has died.[2]

The Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia states:

"Patients have a right to expect that doctors and their staff will hold information about them in confidence, unless release of information is required by law or public interest considerations.

Good medical practice involves:

- Treating information about patients as confidential.
- Appropriately sharing information about patients for their health care, consistent with privacy law and professional guidelines about confidentiality.
- Being aware that there are complex issues related to genetic information and seeking appropriate advice about disclosure of such information".[3]

A doctor's legal obligation of confidentiality arises out of common law. There is also a wide range of legislation which provides for the protection of confidences. The reported case law suggests that civil actions based on breach of confidentiality by doctors are very infrequent but doctors may be the subject of a complaint and disciplinary action for a breach of confidentiality.

Exceptions to the Duty of Confidentiality

A doctor's duty of confidentiality is not absolute. Doctors can provide information about a patient to a third party without it constituting a breach of confidentiality in the following situations:

1. Express or implied consent of the patient to the release of the information
This includes the disclosure of information to another health professional to ensure the appropriate medical care and treatment of the patient.

2. Mandatory disclosure under compulsion of law
This may include a subpoena, summons, search warrant or other Court order requiring the provision of information. There is also a wide range of legislation which varies in each state and territory and requires doctors to disclose information about their patients. This legislation includes:

- Mandatory notification of child abuse – legislation exists in all states and territories, although in WA there is mandatory reporting of child sexual abuse only.
- Reporting of "notifiable diseases" – these are generally infectious diseases where notification is required for public health purposes and the identity of the patient is not always disclosed.
- Notification of births and deaths.

3. Overriding duty in the "public interest" to disclose information
These are often difficult and complex cases. The doctor has to decide whether their duty to the community outweighs that to their patient. The legal scope of the public interest exception to the duty of confidentiality is often unclear. However, for certain disclosures there is legislation that protects and indemnifies the doctor from the patient taking civil action against them.

As a general principle, the public interest exception recognises that there may be a need to breach patient confidentiality in exceptional circumstances because of an overriding public interest favouring disclosure of information to an appropriate third party. This arises in limited circumstances where there is a serious and imminent threat to an individual's life, health or safety; or a serious threat to public health or public safety. This exception generally relates to emergencies.

The Privacy Commissioner states:

"A 'serious and imminent' threat to an individual's life, health or safety relates to a harm that could be done to any person (including the patient seeking treatment and care).

A "serious" threat must reflect significant danger, and could include a potentially life threatening situation or one that might reasonably result in other serious injury or illness. Alternatively, it could include the threat of infecting a person with a disease that may result in death or disability. A threat could also relate to an emergency, following an accident, when an individual's life or health would be in danger without timely decision and action.

A threat is "imminent" if it is about to occur. This test could also include a threat posed that may result in harm within a few days or weeks. It is much less likely to apply to situations where the risk may not eventuate for some months or longer.

A "serious" threat to public health or public safety relates to broader safety concerns affecting a number of people. This could include the potential spread of a communicable disease, harm caused by an environmental disaster or harm to a group of people due to a serious, but unspecified, threat."[4]

In this situation, the disclosure should only be made to a responsible authority with a proper interest in receiving the information. The exception also allows for disclosure to an individual whose life, health or safety is threatened.

An example of the requirement to disclose

Probably the most common example of the requirement to disclose in the "public interest" is that of a patient who refuses to stop driving despite medical advice to do so. In this case, the doctor can report the patient to the relevant Driver Licensing Authority (DLA).

In every state and territory, a doctor who notifies the DLA in good faith is protected from civil and criminal liability (note: in the Northern Territory and South Australia doctors have a mandatory obligation to report to the DLA if they believe a driver is physically or mentally unfit to drive).

Additionally, under amendments introduced in October 2009 to the Privacy Act, a doctor can disclose a patient's genetic information, without the patient's consent, in circumstances when there is reasonable belief that disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of his or her genetic relatives.[5] Importantly, these amendments do not oblige disclosure of the information but allow disclosure to occur if needed.

Conclusion

Confidentiality is a fundamental basis of the doctor-patient relationship. Complex issues can arise for doctors in balancing the duty of patient confidentiality and the doctor's duty to society at large. MDA National encourages its Members to seek advice from an experienced colleague and the 24/7 Medico-legal Advisory Service in these circumstances.

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4 Office of the Federal Privacy Commissioner. Guidelines on Privacy in the Private Health Sector. 8 November 2001. Available from: www.privacy.gov.au/materials/types/guidelines/view/6517

5 *NHMRC and Office of the Privacy Commissioner. Use and disclosure of genetic information to a patient's genetic relatives under Section 95AA of the Privacy Act (Cth). Guidelines for health practitioners in the private sector. Issued by the NHMRC on 27 October 2009. Available from: www.nhmrc.gov.au/guidelines/publications/e96*

Gilbert Henderson - the quiet inventor

Gilbert Henderson's cineplastic mechanical hand and related material are found in both the College Museum and Archive

During the latter years of World War 2, land mines and hand grenades escalated the number of severe hand injuries. This created an interesting surgical quandary for as BK Rank says: "the more mutilated the hand, the more important was some improvement or restoration of function to what remained."

Although their application was limited, the development of mechanical prostheses for cineplastic amputation stumps did improve the quality of life for some patients.

The idea of limb prosthesis has a long history. The ancient Egyptians were aware of prostheses – items such as a prosthetic toe made of wood and leather have been found in archaeological digs.

The classical author Herodutus documents the story of a Persian soldier named Hegistratus who escaped from a leg iron by cutting off one of his feet. He later replaced the foot with a wooden prosthesis. Medieval knights had iron prostheses –these were heavy and cumbersome and as deformity was a stigma, they were made for aesthetic rather than functional purposes.

The most significant advance in the history of prostheses was that of the 16th century French military surgeon, Ambroise Paré. An advocate of amputation, Paré invented a hinged mechanical hand and prosthetic legs with locking devices.

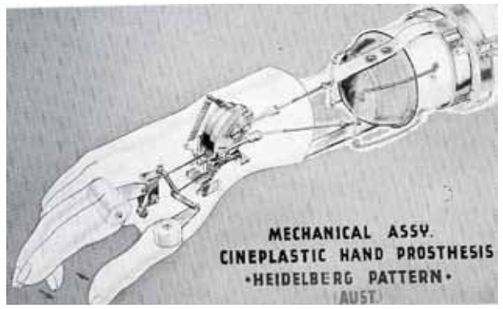
In 1943 Gilbert Henderson who Rank described as an "ingenious man", was sent to 115th Military Hospital, Heidelberg. Henderson was a dentist who had been dean of the Western Australian College of Dental Science. As he "loved designing and making things, which he did with much originality", Henderson's posting to the hospital came at an opportune time.

At Heidelberg, Henderson whose "technical skills extended far beyond technical prosthetic work over a wide range of mechanical contrivances", designed facial shields to restore soft tissue loss and more significantly, developed a cineplastic hand prosthesis – the Heidelberg Pattern.

This complex device was documented in an article by BK Rank and Henderson which appeared in *Surgery, Obstetrics and Gynaecology* in 1946. Activated by the principle of muscle pull, the mechanism connected a system of stirrups and transmission rods to a toggle system of levers.

It also had a locking device which allowed the hand to have a fixed grip without continued muscle effort. The hand was made of acrylic using the hollow casting technique and as the surface was smooth and slippery, artificial rubber pads were inserted in the thumb and fingers.

Main: Coral Aldritt's drawing of Gilbert Henderson working with acrylic hand; **Below:** Cineplastic Prosthetic Hand; **Bottom:** Back row - Gilbert Henderson in centre, Front row – BK Rank on left.



According to Rank, staff in the X-Ray department at Heidelberg were "stunned by the complexity of detail when asked to report on one of the devices, especially as some practical joker had slipped a mouse into the complex mechanism inside the plastic casing".

Production of the mechanical hand was time consuming and research indicated that only about 40-60 per cent of patients continued to use their prosthesis on a regular basis. Consequently, the Heidelberg Pattern never went past the trial phase. However, it was an influential model and stimulated advances in the prosthetics. In 1959, for example, JT Hueston trialled a cineplastic motor in limb segment next to the amputation region.

Gilbert Henderson's cineplastic mechanical hand and related material are found in both the College Museum and Archive. Collected by past President, Sir Benjamin Rank, they are testament to Rank's appreciation of Gilbert Henderson, the quiet inventor.

Written by College Archivist, ***Elizabeth Milford***

Moss, Diamonds & Sunshine

Write about what you know. Sound advice, I guess. I know a lot about a little. Or a little about a lot. I know a lot of little things that when you put them together can sometimes mean something. And allow me to do something. Hopefully, something good. Or at least better...

I know me.

"Ina is a quiet and conscientious achiever." At least, that is what all my old school report cards say. But for the most part, I think I tended to fly under the radar.

Always "good enough", but never first. Never brilliant like diamonds. More warm and suffusing, like sunshine.

I grew up in the country. I went to a country public school and I had to travel a lot. I came in the Top 10 of my year of 140 students, more than half of whom did not achieve a "recordable" HSC mark (i.e. below 15 per cent).

My mark was just good enough to get into a basic science degree. I had to travel a lot more. My first year marks were just good enough to transfer into advanced science, and to be accepted into what was the equivalent of medical science or "pre-med". I came third in my final year with first class honours in science. This pushed my grade point average up just enough to get into medicine, along with my just enough GAMSAT scores. My slightly above average marks were just enough to get my medical degree comfortably, and my application scores for BST and AST were just enough each time to get in.

I believe that I may have been "discussed" at the Fellowship examinations, and that my particular ray of sunshine in the shorts may have played a part in being seen as just enough to gain Fellowship. Not bad for a little ray of sunshine from the back paddock of "Woop Woop".

I think that surgical training is a high pressure environment, specifically designed to create brilliant diamonds. We start out as moss and algae, detritus on the forest floor. We become peat, then under the right baking conditions – coal. After being subjected to the intense pressure of our chosen training program, Trainees are then transformed into perfect, brilliant little diamonds.

But if you pressurise sunshine, what do you have?

Why, you still have sunshine, of course!

As all good farmers know, sometimes the back paddock produces something out of the ordinary. Something unexpected of a quality or calibre that hasn't been seen for a long time. Sometimes even diamonds. And sometimes even a little ray of sunshine to help our diamonds sparkle and our moss grow.

Congratulations to our convocating Fellows – diamonds sparkling in the sunshine!

Dr Ina Training

Control with research

Simon Liubinas is working to reduce side-effects for brain tumour patients with seizures

A unique collaboration between the departments of surgery, medicine and radiology at the Royal Melbourne Hospital (RMH) is helping surgeons and scientists to understand the molecular mechanisms of tumour associated epilepsy (TAE) in patients with supratentorial gliomas.

Participating in that collaboration is Dr Simon Liubinas, a recipient of the Foundation for Surgery Scholarship in both 2011 and 2012 and who is now in the final year of his PhD.

Dr Liubinas said that gliomas were the most common malignant brain tumours in Australia with more than 1500 cases diagnosed each year with generalised or partial seizures a presenting feature in up to 80 per cent of low-grade tumours and 50 per cent overall.

He said that while anti-epileptic drugs were now used to help control such seizures, they did not always work while the side effects of the high-dose multiple drug therapy required were a major cause of morbidity and impaired quality of life.

Yet while the molecular mechanisms of TAE are currently unknown, previous research performed in the Department of Surgery, University of Melbourne, found that gliomas have much higher levels of glutamate compared to normal brain tissue along with lower levels of a family of excitatory amino acid transporters known as EAAT2 protein.

"These findings strongly support the hypothesis that alterations in the normal glutamate metabolism in glioma cells leads to excess levels of glutamate in brain tumours, affecting the critical peritumoural brain tissue causing neuronal changes that lead to epilepsy," Dr Liubinas said.

"As part of the research being done at the RMH we are using magnetic resonance spectroscopy (MRS) as a non-invasive means of measuring metabolites.

profile

Scholarships and Awards

2012: Professorial Research Award: The University of Melbourne, Department of Surgery (The Royal Melbourne Hospital).

2012: National Health and Medical Research Council Postgraduate Scholarship.

2012: Royal Australasian College of Surgeons Foundation for Surgery Research Scholarship.

2011: Royal Australasian College of Surgeons Foundation for Surgery Research Scholarship.

2010: Melville Hughes Scholarship: The University of Melbourne.

"A preliminary study of seven patients with gliomas demonstrated that peritumoural glutamate levels, as measured by MRS, are higher in TAE positive patients than in TAE negative patients."

Dr Liubinas said his work was particularly aimed at determining whether such non-invasive testing could allow glutamate levels to act as a biomarker for TAE which could then allow for the design of tailored therapy to reduce the use of, and side effects from, conventional anti-epilepsy drugs.

He said that he was also involved in research to see if such MRS testing of glutamate could predict overall survival in glioma patients.

"The ability to non-invasively measure glutamate in the tumour and peritumoural brain already exists and if we demonstrate changes between those patients who are at high risk versus low risk of developing epilepsy then there's no reason why it couldn't be used in clinical practice in the very near future," he said.

"Unfortunately, gliomas can never be totally excised surgically so the goal of any research in this field is to find a way to slow or decrease their growth.

"Now we are looking into various mechanisms via which glutamate acts on the tumour and peritumoural brain and while our research is focused on TAE, any research into gliomas may help with the overall goal of slowing or stopping tumour growth and may even eventually impact on future treatments for epilepsy."

Dr Liubinas is undertaking his PhD under the supervision of Professor Andrew Kaye, Professor Terrence O'Brien, Dr Andrew Morokoff, Associate Professor Kate Drummond and Dr Bradford Moffat.

He said he first became interested in the field when working as a surgical resident at the Royal Melbourne Hospital and later as an unaccredited neurosurgical registrar working under Professor Kaye, Head of the Department of Surgery at RMH and University of Melbourne.

He said he was particularly pleased to be invited to participate as a PhD student because of the collaborative nature of the research.

"This is a unique example of such a collaboration between departments," he said.

"My role as a part-time unaccredited registrar in the department of neurosurgery at RMH gives me access to patients with brain tumours.

"I am then able to conduct a clinical interview regarding their seizure history and then arrange for them to have an MRI scan in the department of radiology, scans which are then examined for glutamate in the Melbourne Brain Centre at RMH.

"I am also able to go to theatre and obtain fresh samples of brain tumour which are incredibly precious from a scientific perspective and literally take them straight from theatre to the laboratory in either the department of surgery or medicine.

"We also hold weekly TAE meetings with neurosurgeons, neurologists, radiologists, laboratory scientists and PhD students making it a wonderful example of bedside to bench collaborative research."

For the future

Upon completion of his PhD and the research component of the training program, Dr Liubinas will next year begin his formal SET1 neurosurgery training, an area of surgery and science that has long held a fascination.

"Every day I am amazed at the surgery that the RMH consultants can perform and the incredible detail of MRI scans that can show the structure and functioning of the brain," he said.

"I feel this is a hugely exciting time to be starting a career as a neurosurgeon.

"It's very humbling to work for such dedicated clinicians and researchers and the scholarships I have received from the College have allowed me to focus on my research and given me a great introduction to academic neurosurgery which will be of great benefit in my future career and hopefully for my future patients."

With Karen Murphy

THE GARNETT PASSE AND RODNEY WILLIAMS MEMORIAL FOUNDATION

awards commencing in 2013

PROJECT GRANTS

Applications are invited for Project Grants for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2013.

Project Grants are for a period of up to three years and must be conducted in an Australian or New Zealand institution. Please note that a current awardee, whose fellowship, scholarship or grant is due to conclude after 30 June 2013, is ineligible.

The annual level of support will be up to AUD100,000 and, within this cap, grants must include the salary of the applicant and/or research assistant(s), on-costs, equipment, maintenance and all other costs. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 31 August 2012

GRANTS-IN-AID

Applications are invited for Grants-In-Aid for research in Otorhinolaryngology or the related fields of biomedical science to commence in 2013.

Grants-In-Aid are for a period of up to two years and must be conducted in an Australian or New Zealand institution. Otolaryngologists or Trainees in the Specialty are eligible to apply. Please note that a current awardee, whose fellowship, scholarship or grant is due to conclude after 30 June 2013, is ineligible.

The annual level of support will be up to AUD50,000 and grants are restricted to equipment and maintenance only. Usually commitments will not be made in which continued support over many years is implied.

Closing Date: 31 August 2012

Further details concerning the above awards together with the current application forms can be obtained from:-

The Executive Officer
The Garnett Passe and Rodney Williams Memorial Foundation
PO Box 577
EAST MELBOURNE VIC 8002
P +613 9419 0280 | **F** +613 9419 0282
E gprwmf@bigpond.net.au

Academics in Las Vegas

AAS 7th Annual Academic Surgical Congress

In February 2012 I was honoured to travel to Las Vegas as the Younger Fellows Leadership Exchange representative to the Association of Academic Surgery (AAS) Academic Surgical Congress (ASC). The meeting was the 7th Annual Congress held in conjunction with the Society of University Surgeons.

The AAS was founded in 1967 and its mission is "the promotion of a shared vision of research and academic pursuits through the exchange of ideas between senior surgical residents, junior faculty and established academic surgical professors".

The Association now has more than 3400 members ranging from registrars to professors and the majority of active members are in an early stage of their careers. Overall, the group is a collection of energetic younger surgeons who are enthusiastically committed to not only clinical practice and research, but to providing leadership and mentoring of younger colleagues.

As the Younger Fellows' visitor, I was fortunate to be invited to the AAS Council meeting prior to the academic conference. The Council meeting discusses reports from committee members who manage portfolios as diverse as ethics, global affairs and surgical outcomes research. It was interesting to see how the group managed issues and concerns that are regularly raised in our own meetings.

One particular issue was how to manage the rising costs of staging educational meetings in the face of decreased support from industry and other third parties. Fortunately, the AAS meeting remains economically viable and it is likely that the next annual meeting will proceed without any industry sponsorship.

The AAS is also looking to expand the use of newer information technology modalities to allow web-based seminars and presentations, and to facilitate interactions between members and mentees.

The Annual Academic Surgical Congress is a three-day meeting with over 1200 delegates and around 800 scientific presentations. The meeting has presentations by medical students, residents and faculty. Presentations range from 'Quickshot' five-minute presentations to two-hour panel sessions. There were also presentations from lifetime achievement award winners.

The program

This year Patricia Donohoe, a Paediatric Surgeon, and Norman Rich, a Military and Vascular Surgeon, were honoured for their immense contributions to academic surgery. The title of this year's educational panel discussion was "The 80 Hour Work Week: Where Are We Now and Where Are We Going?" Speakers included representatives of the American College of Surgeons, the American Board of Surgeons and the Accreditation Council for Graduate Medical Education (ACGME).

The panel discussion produced some lively debate on a topic that would probably raise more than a few eyebrows in Australia and New Zealand. The 'Quickshot' sessions allow presentation and discussion of 15 three-minute papers in two hours and cover a wide range of topics.

I was fortunate to chair a session titled "The Continuum of Surgical Education" and was impressed by the educational content and the quality of presentations by medical students and residents. There was robust discussion, in particular, on the issue of gender inequality during surgical training; a topic that may be an under-appreciated problem in our region.

The Congress is a tremendous forum for the presentation of basic and applied scientific research. There are 13 concurrent tumour-focused sessions with 5-10 minute presentations and 90-minute plenary sessions which this year included presentations on "Surgery in the Elderly", "Maintaining and Expanding Your Academic Surgical Career" and "The State-of-the-Art in Minimally Invasive Surgery".

"The group is a collection of energetic younger surgeons who are enthusiastically committed to not only clinical practice and research, but to providing leadership and mentoring of younger colleagues"

In recognition of the strong relationship between the AAS and RACS there is a scholarship awarded at the Surgical Research Society of Australasia meeting that allows the recipient to present their work in this forum. This year's recipient was a surgical trainee from Canberra, Connor O'Meara, who presented his research work on cardiac ischaemia reperfusion injury. Connor's report on his ASC experience has been published in the April 2012 edition of *Surgical News*.

The Leadership Exchange relationship between the RACS and the AAS also provides funding for an AAS member to attend our ASC. This year's recipient was Assoc Prof Allan Tsung, from the University of Pittsburgh Medical Centre. Several other AAS members also presented at the Developing a Career in Academic Surgery (DCAS) course prior to the ASC in Kuala Lumpur

In summary, the AAS ASC is an exciting meeting that I would recommend to young surgeons considering an academic career. I again wish to thank the Younger Fellows Committee and Johnson & Johnson for sponsoring my visit to the meeting.

Warren Hargreaves
Recipient, Younger Fellows Leadership Exchange

Further information on RACS/AAS Younger Fellows Leadership Exchange can be found on the College website or via email at younger.fellows@surgeons.org Applications for the Younger Fellows Leadership Exchange open in September, 2012.

Case Note Review

This is the second case study for *Surgical News* in a series of case note reviews taken from the Australian and New Zealand Audit of Surgical Mortality (ANZASM).

The study provides important lessons for all surgeons that, if learnt, can lead to better outcomes for our patients. The cases come from both the private and public systems across Australia. ANZASM is proud of the expansion of the audit into the private hospital system and is pleased that the forward-looking hospitals see this as a useful tool in their quality control systems. Many cases come from the public hospital system as this is where many of the elderly patients with acute surgical problems are treated. A theme that is common to many of these cases is the need to have in place systems that provide adequate handover of care, as well as prompt notification of problems or change in the condition of the patient.

The Commonwealth Qualified Privilege legislation ensures the data in these cases can only be used for the purposes of the audit so contributions from treating surgeons and from assessors are absolutely confidential and privileged. Information is obtained under this quality assurance activity. Details that may identify individuals have been changed, although the clinical scenarios remain intact.

I trust you find this case note review booklet an educational opportunity and welcome any constructive feedback.

Inadequate DVT Prophylaxis leads to Pulmonary Embolus

SUMMARY: An elderly patient was admitted for a knee replacement. The operation proceeded uneventfully and the patient's initial recovery was unremarkable. In the middle of the sixth post-operative day the patient was assisted to the toilet. A short while later the alarm was sounded. When answered, the patient was found collapsed. Resuscitation was unsuccessful. No post-mortem was undertaken.

Collapse following a call to stool is a classical presentation of pulmonary embolus (PE). Although a PE was considered the likely diagnosis by the medical officer attending the arrest call, it does not appear to have been considered as a possible diagnosis by the surgeon. The surgeon indicated that subcutaneous heparin was used as a DVT prophylaxis. On the medication chart the first dose of subcutaneous heparin appears to have been given some 30 hours after the commencement of the surgery. The nurse progress chart suggests that a foot pump was used on the operation day, but thereafter neither a pump nor anti-embolic stockings were used.

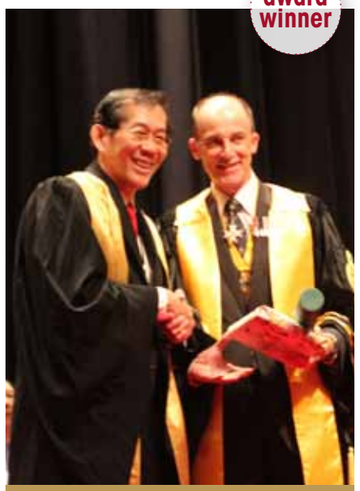
Comment

Knee surgery is a high risk procedure for DVT and PE, and DVT prophylaxis must be administered in a timely fashion. Presumably prophylactic subcutaneous heparin was the surgeon's intended antithrombotic management, but it does not appear to have been administered as ordered.

Guy Maddern
Chair, ANZASM

CONGRATULATIONS on your achievements

Associate Professor Siew Kheon Lum MBBS FRCSEd FAMM FACS FAMS (Hon) Honorary Fellowship



Associate Professor Siew Kheon Lum
Honorary Fellowship

Associate Professor Siew Kheon Lum is a distinguished Malaysian surgeon who is the immediate Past President of the College of Surgeons within the Academy of Medicine of Malaysia.

He graduated from the University of Malaya in 1976 and pursued his early surgical training in Australia. Subsequently, he went to the UK and worked at the Hammersmith Hospital in London and the Queen Margaret Hospital in Scotland, obtaining the Fellowship of the Edinburgh College.

After returning to Malaysia in 1983 he worked for the Ministry of Health and established a surgical unit at Jerang Hospital. He worked at several provincial hospitals in several states including Sarawak.

Professor Lum became a member of the Academy of Medicine of Malaysia in 1983, was elevated to Fellow in 1997 and elected to the Council in 2006. He was engaged in numerous committees and leadership roles reviewing evidence-based medicine and the development of clinical practice guidelines.

He was elected to the Council of the College of Surgeons in 2001 and was President for three years from 2007 to 2010.

He is currently Associate Professor of Surgery at the International Medical University and consultant surgeon to numerous hospitals in Kuala Lumpur and elsewhere in Malaysia.

Professor Lum has published scientific articles and two books. His lectures reveal his interests in quality, safety and ethical health care. He was the prime mover in the establishment of the American College of Surgeons Advanced Trauma Life Support courses in Malaysia and he is now the course director.

He is great communicator and facilitator at a regional level and has co-operated with the Royal Australasian College Of Surgeons in numerous joint activities. He has a broad vision for improving standards of surgical care in South-East Asia and participated in the first international Conference on Surgical Education and Training sponsored by our College in Melbourne. He has contributed to our conferences and has been very influential in assisting the organisation of the 2012 RACS Annual Scientific Congress in Kuala Lumpur.

He is a worthy recipient of Honorary Fellowship of the RACS.

Citation kindly provided by Ian Gough

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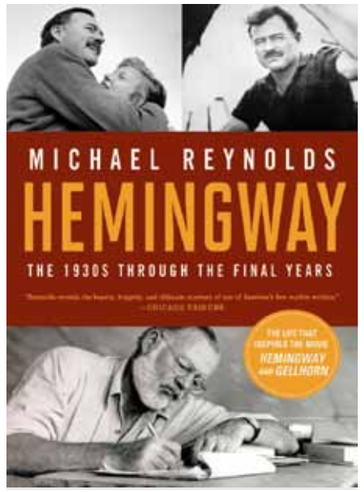

Hemingway: The 1930s Through the Final Years

Michael S. Reynolds
9780393343205 | Pbk | 800 pages
April 2012, Norton

~~AU$29.95~~ | AU$22.46
Member Price

Insightful and revealing this book brings together for the first time two books Hemingway: The 1930s and Hemingway: The Final Years to offer readers a captivating look at this crucial period of Hemingway's life. Written by Michael Reynolds, Hemingway's 'supreme' biographer, the book focuses on the relationship between author Ernest Hemingway and war correspondent Martha Gellhorn, and chronicles their torrid five-year marriage throughout the Spanish Civil War, as well as the aftermath.

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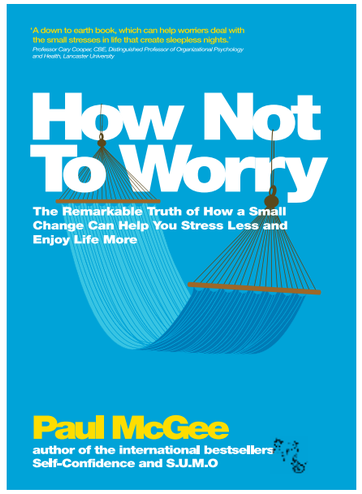

How Not To Worry: The Remarkable Truth of How a Small Change Can Help You Stress Less and Enjoy Life More

Paul McGee
9780857082862 | Pbk | 256 pages
April 2012, Capstone

~~AU$22.95~~ | AU$17.21
Member Price

In How Not to Worry Paul McGee shows us that there is a way to tackle life's challenges in a calmer and more considered way. It is possible to use a certain degree of worry and anxiety to spur us on towards positive, constructive action, and then leave the rest behind. With down to earth, real life advice, How Not to Worry helps us understand why worrying is such a big deal and the reasons for it, exposing the behavioural traps we fall into when faced with challenges. It then helps us to move on with tools and ideas to deal with our worries in a more constructive way.

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iPad Secrets (Covers iPad, iPad 2, and 3rd Generation iPad)

Darren Murph
9781118247365 | Pbk | 360 pages
March 2012

~~AU$37.95~~ | AU$28.46
Member Price

Most iPad users are familiar with the product's basic functions, but the iPad offers an endless array options, and one doesn't need to be a pro to understand. iPad Secrets provides the millions of iPad owners with a true behind the scenes look into a vault of features and little known short cuts of this sea changing tablet. Direct from a product reviewer at Engadget, the world's most read tech blog, iPad Secrets provides practical information to vastly improve one's tablet experience, and to make the device more useful as a tool.

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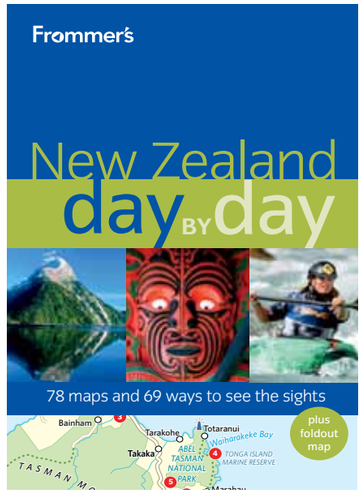

Frommer's New Zealand Day by Day

Adrienne Rewi
9780470894576 | Pbk | 504 pages
February 2012

~~AU$32.95~~ | AU$24.71
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- The cultural "Spotlight" sections take a closer look at the most compelling aspects of New Zealand culture and include explorations of Rugby, Maori arts and crafts, and the booming filmmaking industry.
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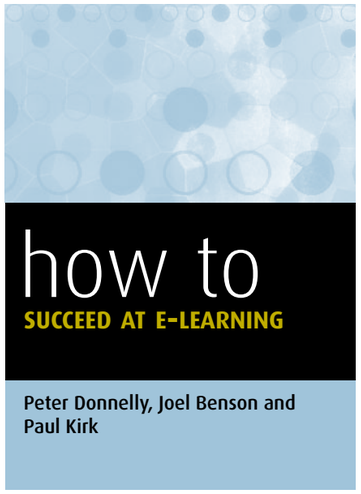

How to Succeed at E-learning

Peter Donnelly, Joel Benson, Paul Kirk
9780470670231 | Pbk | 160 pages
July 2012

~~AU$57.95~~ | AU$43.46
Member Price

How to Succeed at e-Learning answers the needs of all healthcare professionals either starting or continuing their studies but not knowing where to begin with e-learning. It is a valuable guide for learners in undergraduate and postgraduate medicine as well as related health professionals and essential for teachers of medicine who are beginning to transfer from print to electronic teaching and need to understand effective methods of presentation.

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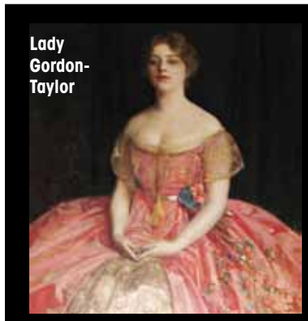

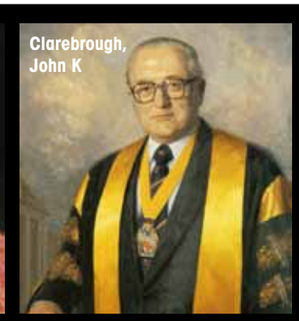

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